ARIZONA STATE MEDICAID HEALTH INFORMATION TECHNOLOGY PLAN 2016 Version 7.0

November 22, 2016
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REVISION HISTORY

AHCCCS initially submitted its SMHP in 2011. Since then, AHCCCS has submitted three major revisions, with Version 5 submitted August 2014. Version 5 includes numerous updates, which are reflected throughout the document.

Version Number	Submission Date	Section	Comments
1.0	March 22, 2011	All	Submission to CMS for Approval
2.0	July 18, 2011	CMS Approval Letter for SMHP Version 1.0, Appendix A changes made	Submission to CMS for Final SMHP Approval in response to 6/16/2011 Conditional Approval Letter 9/14/2011 via email
3.0	May 9, 2013	2013 program changes, e.g., patient volume	Not approved
4.0	July 22, 2013	All	Submission to CMS for approval to implement 2014 Meaningful Use Stage 1 changes and update Arizona's current environment and HIT landscape. Approved November 19, 2013.
5.0	*August 29,2014*	*All*	*Changes have been made throughout the document. Refer to Appendix B for a description of these changes including the addition of significant new information on the HIE vision, information on programmatic changes described in IAPD requests, new landscape assessment information, changes to program metrics and targets, and updates throughout.*
5.1	*December 10, 2014*	*Section C – Administer and Oversee the EHR Payment Program*	*Responding to questions 10, 15, 17, 18, 19, 22, 23, 26, 27, 28* *Section B question 10*

6.0	*November 20, 2015*	*All*	*Changes have been made throughout the document. Agency plans for EP Recruitment, MITA Assessment, Audit Support, Provider Satisfaction Survey, Expanded Functionality of ePIP for Administrative Workflows, Approval of EPs in HIE Onboarding, creation of state formula for Fair Share, CQM Consulting Support, Public Health MU Reporting Through the HIE, Behavioral and Clinical Health Integration and Use of the HIE, Revision of the Agency HIE Participation Agreement, Staff Augmentation for Administration and Programming Support.*
7.0	*November 2016*	*All*	*Responses to questions from last year's approval letter have been added. A crosswalk is included to assist with finding responses. All tables and figures with available current data have been updated. HITECH funding requests have been included for approval for onboarding non-eligible Medicaid providers, (SMD #16-003) , new eRx campaign to stimulate increased use of e-prescribing, integrated IT Environment, MITA HITECH Roadmap development, eCQM reporting, SME Support,future state of Public Health Reporting, inclusion of Prescription Drug Monitoring Database, onboarding of BH providers with non-HITECH funds, Staff Augementation for Administration and Programming Support*

Table of Contents

Introduction

Title IV, Division B of the American Reinvestment and Recovery Act (ARRA) established the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs as one component of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Section 4201 of ARRA provides funding for the Arizona Health Care Cost Containment System (AHCCCS) to: 1) Administer the incentive payments to eligible professionals and hospitals; 2) Conduct adequate oversight of the program, including tracking meaningful use by providers and 3) Pursue initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information.

AHCCCS developed its SMHP using the guidance and template provided by CMS. The AHCCCS SMHP is divided into sections A through E, which also follow the SMHP template. These are preceded by this introduction addressing state and AHCCCS background. Each of sections A through E include references to the SMHP Companion Guide to demonstrate compliance with the required elements. Additional information in the appendices also helps to illustrate how the AHCCCS SMHP is in compliance with CMS requirements.

State and AHCCCS Background: Provides background information about the Agency and discusses how the State economy, budget and health care reform are affecting the Agency environment.

Section A: The State's "As Is" HIT Landscape: Describes the environmental scan and assessment conducted with CMS HIT Planning Advanced Planning Document funding and HIT activities impacting the Agency, members, and providers across the State.

Section B: The State's "To Be" HIT Landscape: Describes the vision of the HIT future over the next five years and identifies achievable goals, objectives and points of engagement needed to get the Agency from where it is now to where it wants to be in terms of adoption and use of certified EHRs as well as overall implementation requirements, strategic plans and tactical steps to successfully implement the program and its related HIT and HIE goals and objectives.

Section C: The Administration and Oversight of the EHR Incentive Payment Program: Describes Arizona's implementation plan and the processes to be employed to ensure that AHCCCS providers meet the federal and State statutory and regulatory requirements for the EHR Incentive Program payments.

Section D: The State's Audit Strategy: Describes Arizona's audit controls and oversight strategy for the EHR Incentive Program.

Section E: The State's HIT Roadmap: Provides a graphical and narrative pathway that shows migration from today ("As Is") to where it expects to be in five years ("To Be").

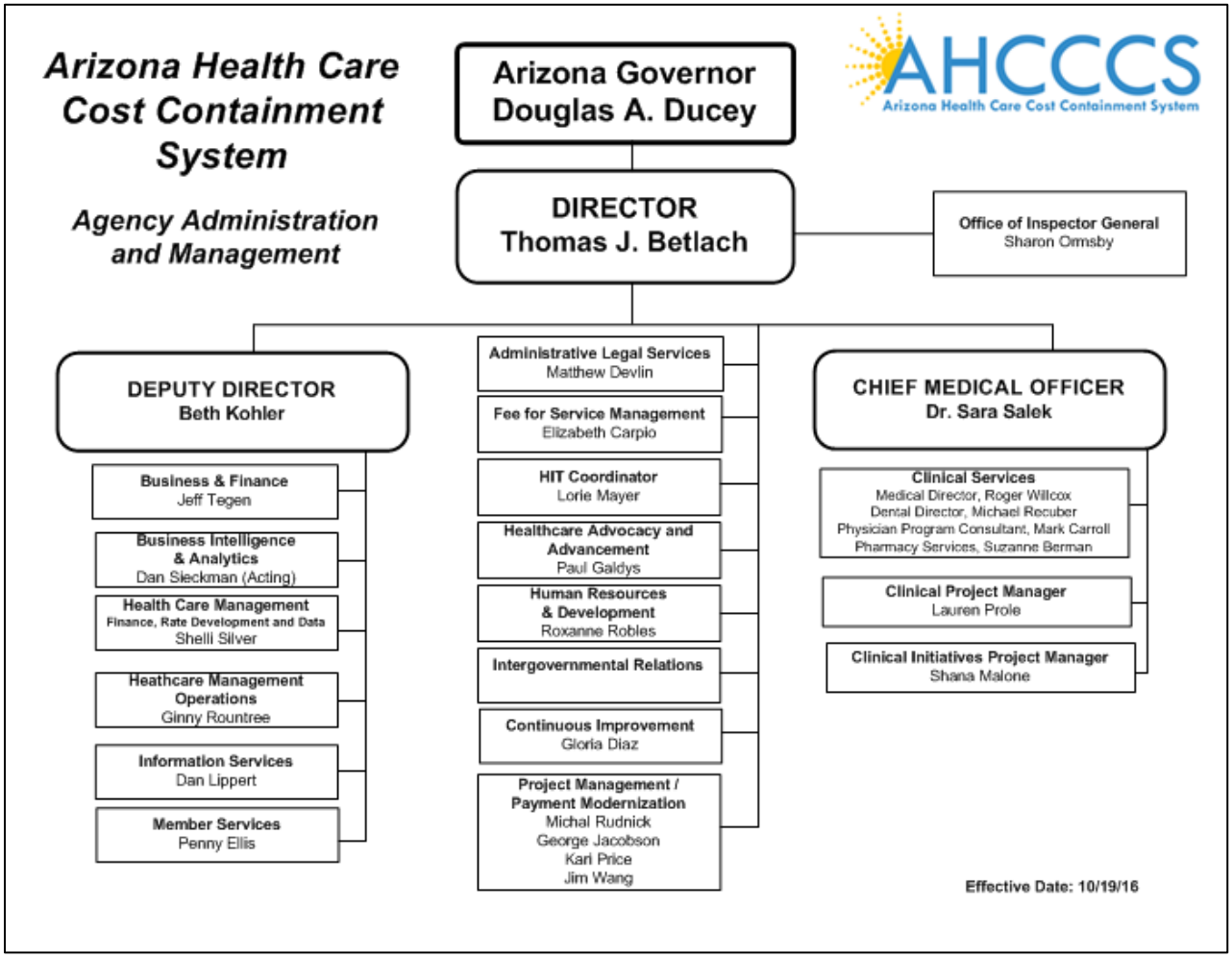
Section F: Appendices - Reference documents include:

- Acronyms
- A Description of AHCCCS Executive Offices and Divisions
- Flexibility Amendment Planning and Approval
- Environment Scan EP Online Survey – Full Survey Questions
- HIE Financial Statements (Submitted under separate cover)
- Statewide HIE Integration Plan – Top 100 Providers
- HIE Participants by Count and Type

Administrative Structure

Arizona's Medicaid EHR Incentive Program is administered by AHCCCS, which is organized as described in Figure 1 below. Arizona has a state Health Information Technology (HIT) Coordinator who also serves as the Medicaid HIT Coordinator. The HIT Coordinator reports to the Director of the AHCCCS Agency. The Medicaid HIT Coordinator provides leadership for the Agency's EHR Incentive Program and the development of the Agency's health information exchange (HIE) strategy.

Figure 1: Arizona Health Care Cost Containment System Organizational Chart



Data Source: AHCCCS OOD, October, 2016

Appendix F.2 describes AHCCCS Executive Offices included in the organizational chart above. For executive oversight of the EHR Incentive Program and the Agency's HIT/HIE strategy development, the Agency has formed a HIT Steering Committee. See the table (below).

The HIT Steering Committee reviews and approves major program changes to the AHCCCS Medicaid EHR Incentive Program. The members of the HIT Steering Committee are described below.

Table 1: AHCCCS Steering Committee

AHCCCS HIT Steering Committee
- Director, AHCCCS
- Deputy Director, AHCCCS
- Assistant Director, Division of Business and Finance
- Assistant Director, Division of Fee for Services
- Assistant Director, Division of Health Care Management
- Assistant Director, Division of Member Services
- Assistant Director, Information Services Division
- Assistant Director, Office of Administrative Legal Services
- Assistant Director, Office of Intergovernmental Relations
- Administrator, Division of Health Care Management/Clinical Quality Management
- Administrator, Division of Health Care Management/Reimbursement
- Chief Medical Officer
- Administrator, Office of Inspector General
- Medicaid HIT Coordinator

Population Distribution

Arizona has fifteen counties, mostly rural, with population concentrations in Maricopa County (Phoenix) and Pima County (Tucson). See the map below.

Figure 2: State of Arizona and Counties

Population Highlights

The AHCCCS Population Highlights provides detailed information regarding the number of members in the AHCCCS population receiving full Medicaid benefits. This category also provides statistics on those populations not eligible for full services, but fall into different categories of eligibility that receive limited health services through AHCCCS.

Table 2: AHCCCS Population Highlights

AHCCCS Population Highlights October, 2016						
	5/1/16	**6/1/16**	**7/1/16**	**8/1/16**	**9/1/16**	**10/1/16**
AHCCCS Acute	1,615,754	1,629,672	1,632,858	1,647,021	1,661,184	1,668,646
KidsCare	621	595	549	528	2,819	5,911
ALTCS[1]	57,984	58,267	58,343	58,413	58,519	58,665
Partial Services (FES,SLMB,QI-1, Transplant Option 1&2)	158,793	161,044	162,376	163,785	165,484	167,570
Total Population[2]	1,833,152	1,849,578	1,854,126	1,869,747	1,888,006	1,900,792

[1] Includes both ALTCS population and the Freedom to Work (FTW) ALTCS members.
[2]Updated to include SLMB/QI-1 & Transplant Option 1&2

Data Source: AHCCCS Website: October, 2016

Agency's Priorities for Providing Comprehensive Quality Healthcare

AHCCCS has a multi-pronged strategy with numerous initiatives to address health care priorities. The four overarching agency priorites are:

1) Bending the Cost Curve While Improving the Member's Health Outcomes

2) Pursuing Continuous Quality Improvement

3) Reducing Fragementation in Healthcare Delivery to Develop an Integrated System of Healthcare and

4) Maintaining a core organizational capacity, infrastructure and workforce

These efforts will accelerate the delivery system's evolution towards a value-based integrated model that focuses on whole person health throughout the continuum and in all settings. Each of the components of the Arizona strategy will improve population health, transform the health care delivery system and/or decrease per capita health care spending.

AHCCCS is also targeting efforts to specific areas where HIT and HIE can bring about significant change and progress: behavioral health; partnerships for integrated care; super-utilizers; American Indian care coordination; coordination between AHCCCS plans and Qualified Health Plans; and justice system transitions.

Further, AHCCCS recognizes that it must develop the mechanisms needed to incorporate electronic health information into clinical quality performance measures such as HEDIS measures, CHIPRA measures, Adult Core Measures and Meaningful Use measure validation.

Currently, the Agency receives administrative data in the form of encounters or claims from AHCCCS MCOs (Managed Care Organizations). However, the data that is in EHRs is richer and more actionable than what is currently available to AHCCCS. Certified EHR technology (CEHRT) will offer a much more robust and timely data source than administrative data, providing information such as laboratory values, indicating improvement in a member's health status or condition, and whether comprehensive preventive and follow-up services were provided during a visit, such as those required under the federal Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) Program. Use of the data contained in EHRs may also provide an opportunity to focus intervention activities to improve clinical outcomes as well as enhance State and Federal reporting capabilities.

Section A The State's "As Is" HIT Landscape

A.1 Extent of EHR Adoption by Practitioners and Hospitals

(SMHP Companion Guide Question A #1)

Eligible Professional Participation in the EHR Incentive Program

Arizona has made significant progress in administering the EHR Incentive Program since the last submission of its SMHP in December of 2015. The table below represents, by year, the current number of new EPs registered with the Medicaid EHR Incentive Program.

Table 3: Arizona EHR Incentive Program Registrations by Provider Type *

AHCCCS Providers Registered for EHR Incentive Program by Registration Year							
Provider Type	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**Total**
Certified Nurse Mid-Wife	50	42	6	9	5	19	**131**
Dentist	84	77	57	56	59	30	**363**
DO- Physician	105	120	69	43	28	24	**389**
MD- Physician	747	1,398	434	293	188	112	**3,172**
Physician's Assistant	12	22	6	14	2	6	**62**
Registered Nurse Practitioner	198	285	182	170	131	107	**1,073**
Total	**1,196**	**1,944**	**754**	**585**	**413**	**298**	**5,190**

*2016 Data is Year to Date data as of September 2016
Data Source: AHCCCS Business Intelligence September 2016

The table below represents the count and type of Arizona Hospitals registered in the Medicaid EHR Incentive Program.

Table 4: Arizona Registered Eligible Hospitals

Registered Eligible Hospitals	
Type	Registered Count
Acute Hospitals	54
Children's Hospitals	2
Critical Access Hospitals	10
Indian Health Service/638 Hospitals*	10
Total Count	76

Data Source: AHCCCS EHR Activity Report, June, 2016
*Note that some Indian Health Service hospitals also have a CAH licensure status in Arizona.

EP Program Attestations and Payments

There are 3,301 EPs that have achieved AIU and 1,558 EPs that have achieved at least MU Stage 1 and MU Stage 2 since the inception of the EHR Incentive Program. See the table below.

Table 5: Arizona EHR Incentive Program Attestation Status

Arizona EHR Incentive Program Attestation Status		
	Attestations Submitted 2011 to July, 2016	**Attestations Paid** Through July, 2016
AIU	3900	3301
MU1 Stage 1 Year 2	1470	1090
MU2 Stage 1 Year 3	656	434
MU3 Stage 2 Year 4	162	34
MU4 Stage 2 Year 5	9	0
Total	6197	4859

Data Source: AHCCCS EHR Team, July 2016

Eligible Hospital Program Attestations and Payment Summary

The following table is a summary of the payment history for every registered and eligible hospital since the inception of the EHR Incentive Program in 2011. The table shows each hospital by CCN (CMS Certification Number) number and the year they received first, second, third or fourth year payments.

Table 6: AHCCCS Payment Status of Eligible Hospitals

CCN	Organization Name	dba (Alternate Organization Name)	AHCCCS Payment Years			
			1	2	3	4
030126	Apache Junction Hospital, LLC	*Arizona Regional Medical Center*	2012			
030107	Arizona Spine and Joint Hospital					
030088	Banner Baywood Medical Center		2011	2012	2013	Rev
030061	Banner Boswell Medical Center		2011	2012	2013	Rev
030093	Banner Del E Webb Medical Center		2011	2012	2013	2014
030065	Banner Desert Medical Center		2011	2012	2013	Rev
030115	Banner Estrella Medical Center		2011	2012	2013	2014
030122	Banner Gateway Medical Center		2012	2013	2014	
030134	Banner Goldfield Medical Center		Rev			
030002	Banner Good Samaritan Medical Center		2011	2012	2013	2014
030016	Banner Health	*Banner Casa Grande Regional Medical Center*	2012	2013	2014	
030033	Banner Health	*Banner Payson Medical Center*	2012	2013	EFT	
030105	Banner Heart Hospital					
030130	Banner Ironwood Medical Center		2014			
030089	Banner Thunderbird Medical Center		2011	2012	2013	2014
030111	Banner University Medical Center South Campus LLC	*University Physicians Hospital*	2012	2014		
030064	Banner University Medical Center Tucson Campus LLC	*University Medical Center Corporation*	2011	2013	2014	
031301	Benson Hospital Corporation		2011	2012	2013	App
031312	Bisbee Hospital Association Copper Queen Community Hospital	*Copper Queen Community Hospital*	2011	2012	2013	
030101	Bullhead City Hospital Corporation	*Western Arizona Regional Medical Center*	2012	2013	Pend	
030100	Carondelet Heart & Vascular Institute		2011	Deny	Term	Term
030119	Catholic Healthcare West	*Mercy Gilbert Medical Center*	2011	2013	2014	
030024	Catholic Healthcare West	*St. Joseph's Hospital and Medical Center*	2011	2013	2014	
031314	Cobre Valley Regional Medical Center		2011	Deny		
031303	community healthcare of douglas inc	*Southeast Arizona Medical Center*	2011	2013	Deny	
031300	COMMUNITY HOSPITAL ASSOCIATION	*Wickenburg Community Hospital*	2012	2013	2014	
030078	DHEW IND HLTH SV HLTH SVS & MNTL	*Phoenix Indian Medical Center*	2011	2013	2014	
030113	DHHS PHS IHS PHOENIX AREA	*Whiteriver Indian Hospital*	2012	2013	Pend	
031305	DHHS PHS IHS PHOENIX AREA	*Hopi Health Care Center*	2012	Pend		
031307	DHHS PHS IHS PHOENIX AREA	*Parker Indian Hospital*	2013	2014		
030074	DHHS PHS IHS TUCSON AREA IHS TUCSON SELLS INDIAN HOSPITAL	*Sells Indian Hospital*	2011	2012	2013	
030084	DHHS PHS NAIHS CHINLE COMPREHENSIVE HEALTH CARE FACILITY	*Chinle Comprehensive Health Care Facility*	2011	2012	2013	Rev

030036	Dignity Health	*Chandler Regional Hospital*	2012	2013	2014	
030023	Flagstaff Medical Center		2012	Pend		
030132	Florence Hospital at Anthem, LLC		Rev			
030129	Florence Hospital, LLC					
031308	Gila River Health Care Corporation	*(AHCCCS: Hu Hu Kam Memorial Hospital)*	2011	2013	2014	
030120	Gilbert Hospital LLC		2013			
030069	Havasu Regional Medical Center LLC		2011	2012	2013	2014
031313	HCH Tucson Holdings LLC	Holy Cross Hospital	2011	2012	2013	2014
030110	Hospital Development of West Phoenix Inc	*West Valley Hospital*	2011	2013	2014	
030055	Kingman Hospital Inc.	*Kingman Regional Medical Center*	2014			
030067	La Paz Regional Hospital, Inc		2011	2012	2013	
033301	Los Ninos Hospital Inc.	*Hacienda De Los Ninos*	2012	2013	2014	
030022	Maricopa County Special Health Care District	*Maricopa Integrated Health System*	2011	2012	2013	Pend
030103	Mayo Clinic Arizona	*Mayo Clinic Hospital*				
030121	Mountain Vista Medical Center LP		2011	2012	2013	Pend
030068	MT Graham Regional Medical Center Inc.		2013	2014		
031302	Northern Cochise Community Hospital Inc		2011	2012		
030085	Northwest Hospital LLC	*Northwest Medical Center*	2012	2013	Pend	
030114	Oro Valley Hospital LLC	*Northwest Medical Center Oro Valley*	2012	2013	Pend	
030112	Orthopedic and Surgical Specialty Company, LLC	*Arizona Orthopedic Surgical Hospital*				
031304	Page Hospital		2011	2012	2013	Rev
030117	PHC-Fort Mohave Inc	*Valley View Medical Center*	2011	2012	2013	2014
033302	Phoenix Children's Hospital		2013	2014		
030043	RCHP-Sierra Vista Inc.	Sierra Vista Regional Health Center	2011	2012	2013	
030077	San Carlos Apache Healthcare Corporation	*(formerly DHHS PHS IHS PHOENIX AREA dba San Carlos Indian Hospital)*	2013	2014		
030014	Scottsdale Healthcare Hospitals	*John C. Lincoln North Mountain Hospital*	2012	2013	2014	
030038	Scottsdale Healthcare Hospitals	*Scottsdale Healthcare Osborn Medical Center*	2011	2013	2014	
030087	Scottsdale Healthcare Hospitals	*Scottsdale Healthcare Shea Medical Center*	2011	2013	2014	
030092	Scottsdale Healthcare Hospitals	*John C. Lincoln Deer Valley Hospital*	2012	2013	Pend	
030123	Scottsdale Healthcare Hospitals	*Scottsdale Healthcare Thompson Peak Medical Center*	2011	Deny		
030010	SMSJ Tucson Holdings LLC	*St. Mary's Hospital*	2011	2012	2013	2014
030011	SMSJ Tucson Holdings LLC	*St. Joseph's Hospital*	2011	2012	2013	2014
030037	St Lukes Medical Center LP	*St Lukes Medical Center & Tempe St. Lukes Hospital*	2011	2012	2013	Pend
030062	Summit Healthcare Association	Summit Healthcare Regional Medical Center	2013	Pend		
030108	Surgical Specialty Hospital of Arizona LLC					
030071	The Fort Defiance Indian Hospital Board, Incorporation	*Fort Defiance Indian Hospital*	2012	2013	2014	
030073	TUBA CITY REGIONAL HEALTH CARE CORPORATION	*Tuba City Indian Medical Center*	2012	Deny		
030006	Tucson Medical Center		2011	2012	2013	2014

030007	Verde Valley Medical Center		2012	Pend		
030001	VHS Acquisition Corporation	*Maryvale Hospital (Medical Center)*	2011	2013	2014	
030083	VHS Acquisition Subsidiary Number 1 Inc	*Paradise Valley Hospital*	2011	2013	2014	
030094	VHS of Arrowhead Inc	*Arrowhead (Community) Hospital*	2011	2013	2014	
030030	VHS of Phoenix Inc	*Phoenix Baptist Hospital*	2011	2013	2014	
031315	White Mountain Communities Hospital Inc	*White Mountain Regional Medical Center*	2012	2013	2014	
031311	Winslow Memorial Hospital Inc	*Little Colorado Medical Center*	2012	2014		
030012	Yavapai Community Hospital Association dba YRMC Home Health Services	*Yavapai Regional Medical Center West Campus*	2012	2013	2014	
030118	Yavapai Community Hospital Association dba YRMC Home Health Services	*Yavapai Regional Medical Center East Campus*	2012	2013	2014	
030013	Yuma Regional Medical Center		2011	2013	Rev	
			74	68	53	19

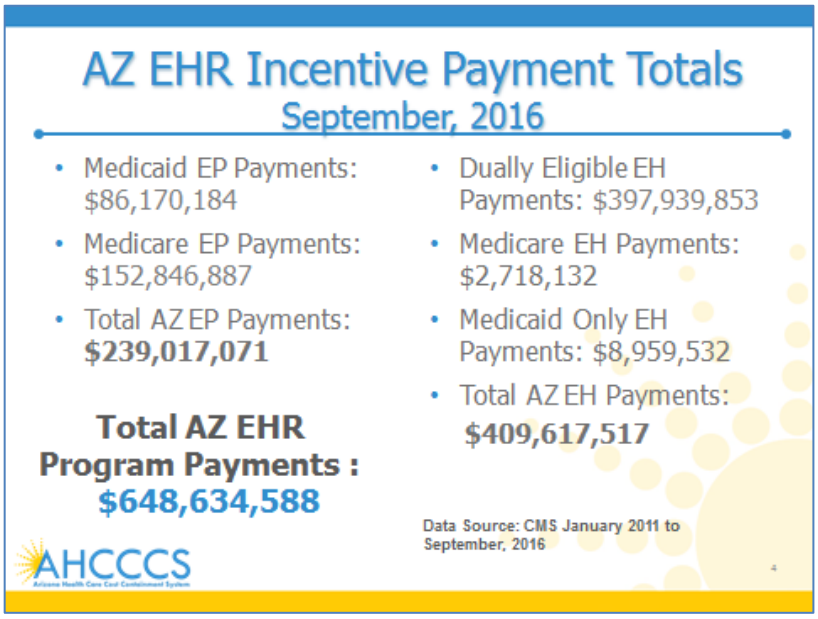
Data Source: EHR Team September, 2016

Total Incentive Payments Received by EPs and EHs in Arizona

There are 80 Hospitals that have registered with CMS for the EHR Incentive Program and 76 which have registered with the Arizona State Level Repository. Of those who have not gotten a payment, the reasons include, not qualifying for the EHR Incentive Program, the hospital is no longer in business, or has been taken over by another organization and are no longer participating. There are 74 hospitals that attested for the EHR program as of this SMHP.

As noted in the figure below, the total amount of EHR Incentive Program payments that have been received by Arizona Eligible Professionals and Eligible Hospitals (including Critical Access Hospitals) equals $646,634,588 as of September, 2016.

Figure 3: Total EH and EP EHR Incentive Program Payments



(Section A.1 Continued)

Summary of AHCCCS EHR Incentive Program Activity ePIP Dashboard Report

On a monthly basis the agency compiles an EHR Incentive Program Activity report which summarizes program payments by EP and EH by Type of Payment (AIU or MU) and by Program Year. See Table 7: EHR Incentive Program Activity Chart (following) to view September, 2016's report.

For the Month of September, 2016 the agency has disbursed a total of 5,213 payments since the program started in 2011. There were 3,450 AIU Payments made to both Eligible Professionals and Eligible Hospitals. There were a total of 1,763 MU payments made with1,647 MU payments made to Eligible Professionals and 116 made to Eligible Hospitals.

The agency is also tracking the number of Recoupments it has made to both Eligible Professionals and Eligible Hospitals. As of the end of September, 2016 a total of 7 Provider recoupments have been made. The Net Provider payment counts for the total number of payments was 5,206. The total number of AIU payments was 3,446, and the number of MU payments disbursed equaled 1,760

Net Provider Incentive Payments from the beginning of the EHR Incentive Program are as follows:

The total amount of EHR Incentive Payments in Program Year 2011= $78,783,957.93

For Program Year 2012, the total amount of Payments = $68,492,691.60

For Program Year 2013, the total amount of Payments = $65,409,071.41

For Program Year 2014, the total amount of Payments =$ 37,383,930.97

For Program Year 2015, the total amount of payments =$2,786,584.00

Please see the table below for more detail.

(Section A.1 Continued)

Table 7: EHR Incentive Program Activity

Arizona Medicaid EHR Incentive Program
for
Eligible Providers

ePIP DASHBOARD REPORT												
EHR INCENTIVE PROGRAM ACTIVITY												
AS OF SEPTEMBER 30, 2016												
PROGRAM TO DATE PAYMENT SUMMARY												
Eligible Providers	**Number of Payments Disbursed**	**Number of AIU Payments Disbursed**	**Number of MU Payments Disbursed**	**AIU Disbursement Amount**	**MU Disbursement Amount**	**Total Disbursement Amount**	**Program Year 2011**	**Program Year 2012**	**Program Year 2013**	**Program Year 2014**	**Program Year 2015**	**Program Year 2016**
EP Disbursements	5,025	3,378	1,647	$71,514,762.00	$14,757,422.00	$86,272,184.00	$27,979,175.00	$25,121,753.00	$17,678,587.00	$12,451,085.00	$2,786,584.00	$255,000.00
EH Disbursements	188	72	116	$79,966,061.21	$87,329,710.35	$167,295,771.56	$50,868,532.93	$43,742,658.25	$47,730,484.41	$24,954,095.97	$0.00	$0.00
All Provider Disbursements	5,213	3,450	1,763	$151,480,823.21	$102,087,132.35	$253,567,955.56	$78,847,707.93	$68,864,411.25	$65,409,071.41	$37,405,180.97	$2,786,584.00	$255,000.00
EP Recoupments (Full)	(6)	(4)	(2)	($85,000.00)	($17,000.00)	($102,000.00)	($63,750.00)	($17,000.00)	$0.00	($21,250.00)	$0.00	$0.00
EH Recoupments* (Full)	(1)	0	(1)	($354,719.65)	$0.00	($354,719.65)	$0.00	($354,719.65)	$0.00	$0.00	$0.00	$0.00
All Provider Recoupments	(7)	(4)	(3)	($439,719.65)	($17,000.00)	($456,719.65)	($63,750.00)	($371,719.65)	$0.00	($21,250.00)	$0.00	$0.00
Net EP Payments	5,019	3,374	1,645	$71,429,762.00	$14,740,422.00	$86,170,184.00	$27,915,425.00	$25,104,753.00	$17,678,587.00	$12,429,835.00	$2,786,584.00	$255,000.00
Net EH Payments	187	72	115	$79,611,341.56	$87,329,710.35	$166,941,051.91	$50,868,532.93	$43,387,938.60	$47,730,484.41	$24,954,095.97	$0.00	$0.00
Net Provider Payments	**5,206**	**3,446**	**1,760**	**$151,041,103.56**	**$102,070,132.35**	**$253,111,235.91**	**$78,783,957.93**	**$68,492,691.60**	**$65,409,071.41**	**$37,383,930.97**	**$2,786,584.00**	**$255,000.00**

Data Source: AHCCCS EHR Team, Activity Report September, 2016

EHR Environmental Scan

Environmental Scan of Eligible Providers to Non Eligible Providers

In Arizona, if a provider has seen one Medicaid patient, that provider needs to enroll in the agency's provider registration system. Once a provider is enrolled they receive an AHCCCS ID number which allows them to bill for the delivery of clinical services. Consequently there are a very high number of Agency registered providers in the agency's provider registration system, but the large numbers of enrolled providers do not indicate patient volume eligibility for this program.

The agency currently has 24,376 MD's and DO's registered as AHCCCS providers in its Provider Registration System. According to our current EHR Incentive Payment Registrations, only 14.6% of the total number of MD's and DO's registered with the agency has registered with the EHR Program.

As demonstrated in the table below, there are 3, 635 Nurse Practitioners registered with the AHCCCS Provider Registration system and 1,073 have registered with the EHR Incentive Program. There are 1,754 Dentists registered with the AHCCCS Provider Registration System and 363 have registered with the EHR Incentive Program. There are almost 61.5% of AHCCCS Registered Certified Nurse Midwives participating in the EHR Incentive Program while only 2.53% of Physician Assistants are participating due to the strict definition of needing to "so lead an FQHC". Overall, the percentage of AHCCCS Providers Registered for the EHR Incentive Program compared to the Total Number of Active AHCCCS Providers is 16%.

Table 8: Total Number of AHCCCS Registered Providers by type Compared to EHR Incentive Registered Providers

Provider Type	Providers Registered EHR	Active AHCCCS Providers	Percent of Providers
CERTIFIED NURSE-MIDWIFE	131	213	61.50%
DENTIST	363	1,754	20.70%
DO-PHYSICIAN OSTEOPATH	389	2,519	15.44%
MD-PHYSICIAN	3,172	21,857	14.51%
PHYSICIANS ASSISTANT	62	2,446	2.53%
REGISTERED NURSE PRACTITIONER	1,073	3,635	29.52%
Overall - Total	**5,190**	**32,424**	

Data Source: AHCCCS Business Intelligence September 2016

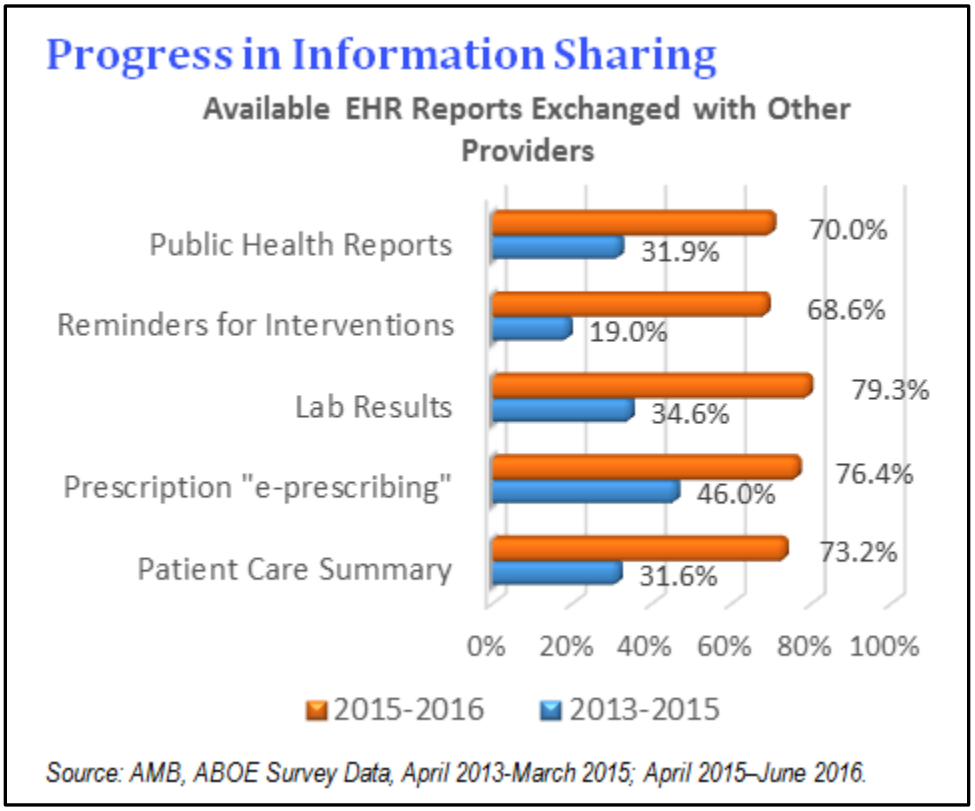
Environmental Scan of MDs and DOs by the Arizona State University Survey of Historical Trends in Physician EHR Adoption

Through a comprehensive survey of all licensed physicians, the Center for Health Information and Research (CHiR) at Arizona State University (ASU) has been tracking provider feedback about their adoption since 2009. According to the September 2016 survey "Physicians Use, Exchange and Evaluation of Electronic Medical Records" the results indicate that the percentage of Arizona physicians using electronic health records increased from about 45% in 2007- 2009 to approximately 90.5% in 2015 – 2016.

The current trend anticipates that almost 100% of all physicians will be using electronic health records by 2018. This is a trend for all physicians, not just Medicaid physicians. The surveys have found that EHR adoptions were largely related to physician age (inverse relationship) and size of practice. In addition, until recently sharing EHRs among providers was limited by the lack of electronic networks. Significant progress is being made in part due to the efforts of The Network, Arizona's state level health information exchange.

The figure below demonstrates the growth of data exchange from the previous survey period to the most current.

Figure 4: Data Exchange Progress



Other findings include:

- EHR use is the least prevalent among solo practitioners.
- There is little difference in the prevalence of EHR use between the two most urban counties and several rural counties.
- Many practitioners who use EHRs are actually not dissatisfied with their EHRs; rather physicians recognize their EHR can offer advantages not available from scanned records or paper medical records.

Other key findings are summarized in this Survey:

- There are 15,087 Total Physician License Renewals that were performed over the two year period
- 10,062 Physicians are employed in Arizona
- 87% of Physicians that renewed their licenses from 2015 – 2016 completed the Physician Survey making this a very large survey response
- There were 5,446 AHCCCS Allopathic Physicians and 586 AHCCCS Osteopathic Physicians that completed the survey
- Based on 15,087 total physician license renewals as of June 2016, the total licensed physicians employed in Arizona were 10,062 of which 7,234 were AHCCCS Physicians.

EHR Physician Use by Physician Practice Type

The table below shows the EHR utilization rate by provider practice type. The physicians that are in City, State or County Clinic or Hospital System recorded the highest EHR utilization rate at 100% followed by Hospital/Medical School Group Practices at 100%.

Physicians that are operating in physician owned solo practices were the lowest utilizers of EHR technology at 72.9%. It should, however, be noted that the category experienced a 10% growth from the last survey.

Community or Rural health Centers were slightly lower than the last survey achieving a utilization rate of 95.7% and Federal Government or Hospital or Clinics remained virtually the same at 96.4%.

Table 9: EMR Utilization by Type of Practice, 2015-2016 (N = 4,077)

Type of Practice	*Utilization Rates*
Physician Owned Solo Practice	72.9%
Physician Owned Group Practice	89.7%
Hospital/Medical School Group Practice	96.6%
Community or Rural Health Center	95.7%
Federal Government Hospital or Clinic	96.4%
Private Hospital System	94.0%
Non-Hospital Private Outpatient Facility	94.4%
Medical School/University Research Center	88.8%
Health Insurer/Health Related Organization that does not provide care	86.4%
City, State or County Clinic or Hospital System	100.0%
Other	92.3%
Hospice or SNF	100.0%
Independent Contractor	50.0%
Medical Consultant	100.0%
Mental/Behavioral Health	91.6%

Source: AMB, ABOE Survey Data, April 2015-June 2016.

Note: Rates = % of physicians within each practice type. 3,503 respondents were missing type of practice. 3,744 respondents were missing EMR utilization.

(Section A.1 Continued - Environmental Scan)

Description of Medicaid Provider Practice by Practice Setting Type

The table below is a summary of the actual numbers of Medicaid providers by the type of practice setting in which AHCCCS physician providers are providing care. Compared to all other providers, Medicaid practices follow the same trends as found in the general physician population.

Table 10: Type of Practice Setting of AHCCCS Physician Providers April 2015-June 2016

(N=3901)

Type of Practice	*Number of Physicians*	*Percent*
Physician Owned Solo Practice	572	14.6%
Physician Owned Group Practice	1,358	34.8%
Hospital/Medical School Group Practice	786	20.1%
Community or Rural Health Center	208	5.3%
Federal Government Hospital or Clinic	149	3.8%
Private Hospital System	328	8.4%
Non-Hospital Private Outpatient Facility	161	4.1%
Medical School/University Research Center	157	4.0%
Health Insurer/Health Related Organization that does not provide care	42	1.0%
City, State or County Clinic or Hospital System	37	0.9%
Other	111	2.8%
Hospice or SNF	7	0.1%
Independent Contractor	7	0.1%
Medical Consultant	25	0.6%
Mental/Behavioral Health	2	0.0%

Source: AMB, ABOE Survey Data, April 2015-June 2016.

Note: 2,131 physicians did not report type of practice (missing). Percentages are based on responses. The five practice types listed under the "Other" section are a subset of the total types included in the Other category.

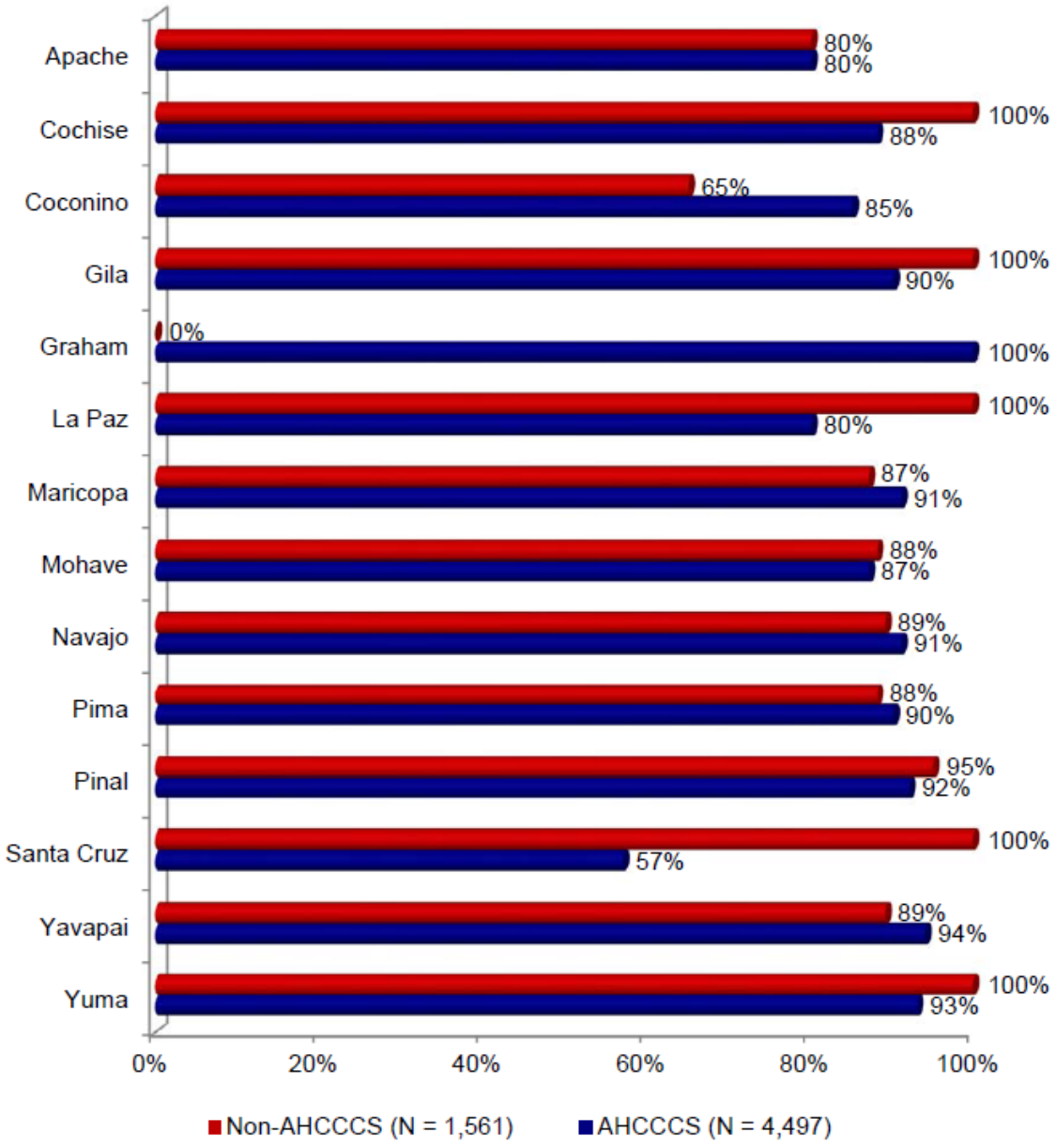
Physician EHR Utilization by County

80% of the state of Arizona's population lives in two counties Maricopa County (Phoenix) and Pima County (Tucson). Physician practice locations parallel the general population where the largest number of physicians is in Maricopa County followed by Pima County. In the chart below, in a unique trend, some of the state's most rural counties have a higher % of Physicians than are reported utilizing an EHR than in some of the metropolitan counties.

The figure below also shows the percentage of utilization of EHR technology of Medicaid physicians compared to non-Medicaid physicians. It should be noted that in the two most populous counties, Pima and Maricopa, the percentage of Medicaid physicians using EHR technology exceeds the number of non-Medicaid physicians.

(Section A.1 Continued - Environmental Scan)

Figure 5: EMR Utilization by County and AHCCCS vs. Non-AHCCCS, April 2015-June 2016
(N= 6,058) Note change in graph from last survey, AHCCCS v. Non-AHCCCS comparison.



Source: AMB, ABOE Survey Data, April 2015-June 2016.

Note: Approximately 1,406 AHCCCS respondents and 586 Non-AHCCCS respondents did not identify a method of storing medical records. 129 AHCCCS and 123 Non-AHCCCS respondents did not identify their county.

Pima and Maricopa Counties represent the urban areas. All other counties represent the rural areas. Greenlee County is excluded as there were no respondents during this period.

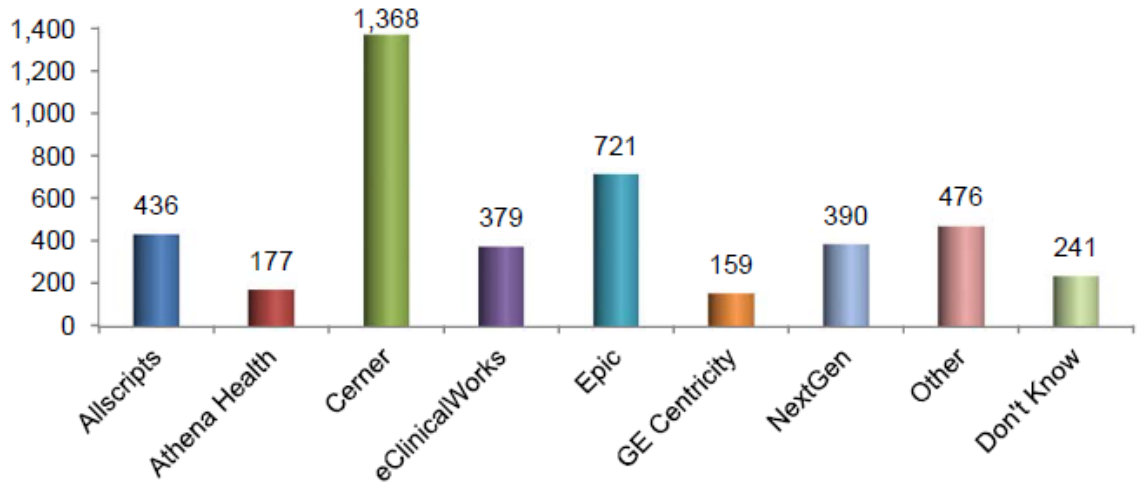
Provider Environmental Scan (continued): EHR Vendor Types

Eligible Professional EHR Vendor Types

In physician groups greater than 130, the two vendors with the largest number of providers in Arizona are Cerner and Epic. Banner Health is the largest health system in the state and uses Cerner for its Hospital EHR systems. Banner Health just recently completed the purchase of the University Physician's Hospital and University Medical Center and will be switching them from EPIC to Cerner. Yuma Medical, Mayo Clinic Hospital and HonorHealth hospital system all use Epic. Allscripts, NextGen and eClinicalworks are also popular with hospital and practice based physicians.

See the table below for a graphical demonstration.

Figure 6: Number of EMR Users by Vendor ≥ 130 Users, April 2015-June 2016



Source: AMB, ABOE Survey Data, April 2015–June 2016.

Note: The "Other" vendor excludes vendors contracted with government hospitals/clinics.

(Section A.1 Continued - Environmental Scan)

Eligible Hospital EHR Vendor Types

The table below is a summary provided by the HIE/The Network as to the name of the participating Hospital and Hospital System and the type of EHRs they are using as of September, 2016.

Table 11: Arizona Hospital EHR Vendors

Arizona Hospital EHR Vendors	
Hospital/System	**EHR System**
Abrazo Health – Vanguard Health Systems	Cerner
Banner Health System	Cerner
Banner University Medical	Epic
Benson Hospital	HMS-Medhost
Canyon Vista Medical Center	Cerner
Carondolet Health Network	Cerner
Cobre Valley Regional Medical Center	Meditech
Community Health Systems	McKesson
Copper Queen Community Hospital	CPSI
Dignity Health System	Cerner
HonorHealth System	Cerner & Epic moving to Epic
IASIS Healthcare	McKesson
Kingman Regional Medical Center	Siemens (Cerner) Sorian
La Paz Regional Hospital	CPSI
Lifepoint Health System	Medhost
Little Colorado Medical Center	HMS
Maricopa Integrated Health System	Epic
Mayo Clinic Hospital	Epic
Mt. Graham Regional Medical Center	Meditech
Northern Arizona Healthcare System	Cerner
Northern Cochise Community Hospital	Medhost
Phoenix Children's Hospital	Allscripts
Summit Healthcare	McKesson
Tuba City Regional Health Care	Alert
Tucson Medical Center	Epic

Wickenburg Community Hospital	CPSI
Yavapai Regional Medical Center	Cerner
Yuma Regional Medical Center	Epic

Source: Arizona Health-e Connection - The Network/HIE, September, 2016

(Section A.1 Continued - Environmental Scan)

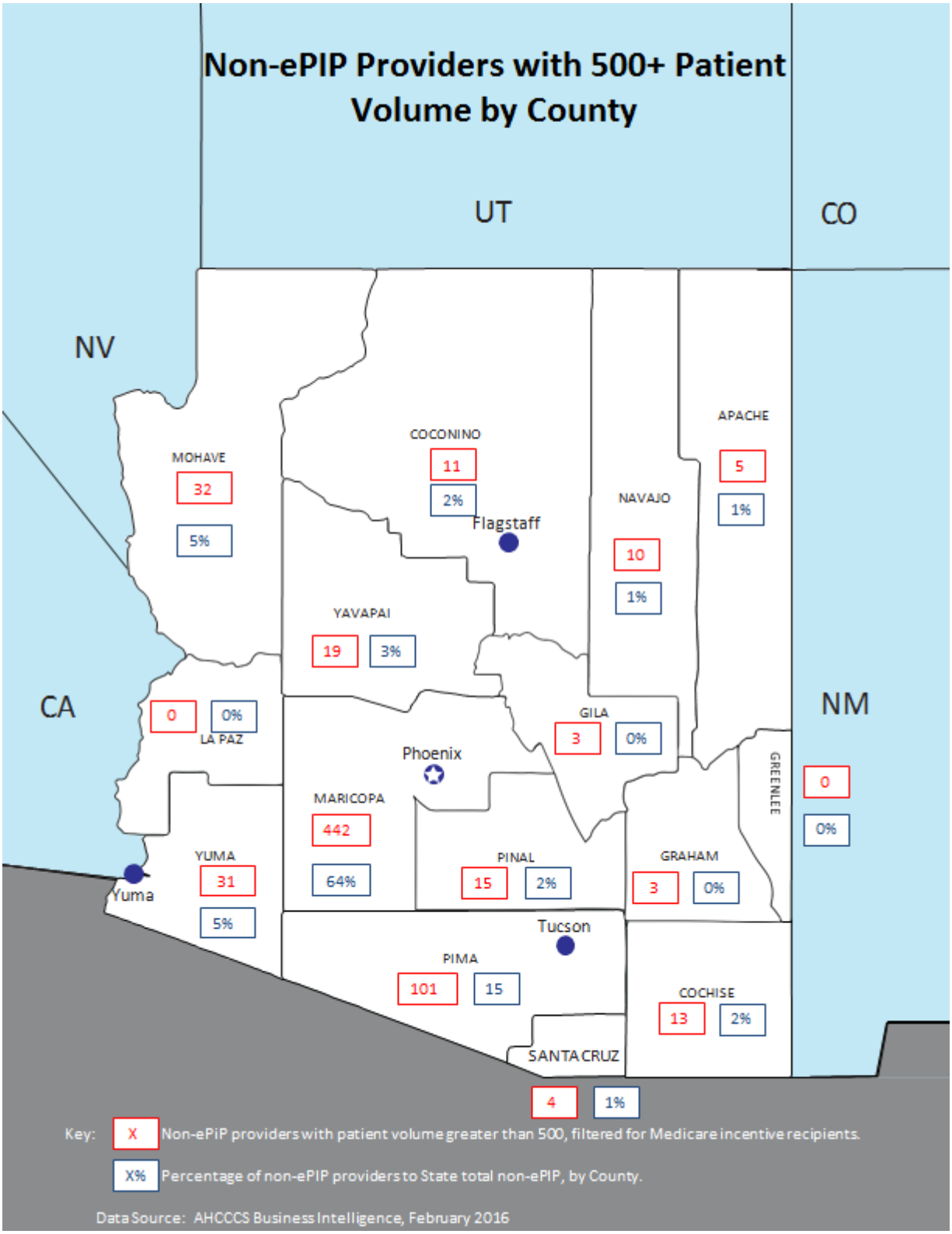
EP White Space Analysis

In order to maximize the number of Medicaid providers participating in the EHR Incentive Program, the SMA conducted a white space analysis to determine the geographic location of non-participating providers. A data pull was conducted comparing the number of potentially eligible Medicaid providers, by county, that have not yet registered in the EHR Incentive program. This data was adjusted for EPs that were already participating in the Medicare EHR Incentive Program and filtered to include only those practices that had a minimum of 500 Medicaid office visits in the previous year.

As demonstrated in the table below, the total number of Arizona eligible professionals not registered in the ePIP program who saw a minimum of 500 Medicaid patients in the previous year was 689. The overwhelming number of unenrolled but likely eligible professionals is in Maricopa County where 442 EPs were identified and in Pima County where 101 EPs were identified as likely eligible but still un-enrolled in ePIP.

This grouping of providers has been the focus of the Education and Outreach contract with the Arizona Health-e Connection, designed to recruit unregistered EPs to the EHR Incentive program and promote progress through the different stages of Meaningful Use.

Figure 7: White Space Analysis and Recruitment Goals



(Section A.1 Continued - Environmental Scan)

AHCCCS Online Survey

Eligible Professional Environmental Scan

AHCCCS conducted an online survey of those providers who attested between 2013 and 2015 to get feedback from them on how the SMA could improve the Registration and Attestation process for those Medicaid Eligible Professionals participating in the EHR Incentive Program. A full copy of the survey instrument is in Appendix F.4. The survey link was sent to over 1,300 Eligible Professionals that had already received a payment from the EHR Incentive Program. Over 16% of the participants responded and the comments and findings were summarized and were action planned.

Survey Content -- A high level view of areas addressed in the survey were as follows:

- Frequency of use and usefulness of reference guides and educational tools provided on the agency website,
- Provider experience with the portal (ePIP) for registration, document submission and attestation,
- Ranking of difficulty for compliance request for data submission (patient volume, patient encounters, etc.)
- Effectiveness of Customer Service support experience when contacting the SMA EHR Team,
- Provider intentions regarding continuing with Meaningful Use progression.

Survey Results – This survey allowed for both numerical rating and a free text response. A summary of the results is as follows:

- Customer Service satisfaction calling the EHR Team was ranked well above the mid-range with staff response, staff knowledge and staff courtesy but fell well below the mid-range regarding timeliness of response.
- Ninety-six percent of the respondents indicated that it was their intent to progress to the next stage of Meaningful Use.
- Sixty-nine respondents or 51 percent of 135 respondents never accessed the agency website to use the reference guides and educational tools or found them not be useful. Of those that did, 32% found them only “somewhat useful”.
- There was a consistent provider concern expressed over timeliness of response to questions and delays in payments.
- The EHR Incentive Program’s provider portal called e-PIP , access and ease of use was analyzed along four parameters; ease of access, ease of navigation, clarity of directions, and clarity of documents required for upload. The respondents ranked the portals functionality as follows:
    - 86% of respondents were either neutral or favorable in their ability to login to the ePIP portal with 14% unfavorable

- 80% of respondents were either neutral or favorable in their ability to navigate the ePIP portal with 20% unfavorable
- 76% of respondents were either neutral or favorable in their ability to understand the directions to the portal were clear and easy to follow; 24% were unfavorable
- 70% of respondents were either neutral or favorable in their ability to understand the types of documents they needed to submit; 30% were unfavorable

- Participants were asked to identify the data elements that were most difficult for them to provide to complete their attestation for the EHR Program. Participants could select multiple elements and 96 providers responded to this question. Their responses are ranked from highest to lowest below:

  - Number 1: Patient Volume Report (55%) 53 EPs selected
  - Number 2: Medicaid Patient Encounters (43%) 41 EPs selected
  - Number 3: Total Patient Encounter Data (41%) 39 EPs selected
  - Number 4: EHR Certification Number (36%) 35 EPs selected
  - Number 5: Hospital Based Encounters (36%) 35 EPs selected

After Survey Action Plan – Following our review of the EP Environmental scan survey, the EHR team has developed the following responses to the findings:

- The SMA has completed its agency wide web redesign and as part of this, the EHR team has already initiated work to improve the navigation for EPs for the EHR program and has posted a portion of the updated education materials. It is expected to be completed by January 1, 2017.
- To improve agency timeliness for response regarding provider questions and payments, the SMA has:
  - Evaluated the ePIP portal for potential modifications for automated response to issues,
  - Hired additional temporary staff to assist with customer service and data research
  - Evaluated risk assessment criteria and training regarding pre-payment audits.
- Patient Volume and Medicaid Patient Encounter reporting requirements have been assessed in the context of improvement of provider education materials and format.
  - Through our Education and Outreach contract with Arizona Health-e Connection, webinars have been conducted on Medicaid patient Volume and Hospital Based Encounters. Copies of the Power Points have been posted on the AHCCCS website at the EHR Incentive Program webpage.
  - An individual Patient Volume webinar has also been conducted and the PowerPoint posted. EP Reference Guides have been updated and placed on the AHCCCS website.

- AHCCCS has expanded the scope of work of the Education and Outreach contractor to allow for it to provide training and education in the use of electronic prescriptions to facilitate compliance with that MU measure. Arizona Health-e Connection is in the process of hiring a pharmacist to lead a comprehensive e-prescribing campaign for all of the eligible professionals.
- AHCCCS has procured consulting services through its Education and Outreach contract to provide support for EP migration through MU stages.

In addition to this online survey of eligible professionals, the agency has gotten provider feedback from the staff that is performing the agency's Education and Outreach project. The feedback from the outreach matches closely with the online survey results.

A.2 Broadband Internet Access Challenges to Rural Areas

(SMHP Companion Guide Question A #2)

Broadband Internet Access Coverage

Arizona is largely rural with high speed broadband access concentrated in a couple metropolitan areas and a few smaller cities and towns. The two metropolitan areas of Phoenix and Tucson account for over 80 percent of the state's population. Broadband internet access does pose a challenge to the state's rural areas for HIT/HIE functionality. *The Arizona Strategic Enterprise Technology Office, or ASET, is the agency who coordinates and implements broadband access. In September 2016 AHCCCS was invited to participate with other state agencies in developing an updated broadband strategy for Arizona and AHCCCS is sending its leadership to represent the health care stakeholders and their needs in increasing bandwidth.*

Health IT.gov has published the following bandwidth speeds to support electronic health record utilization by organization type.

The table below shows the recommended minimum bandwidth speeds for a variety of physician group and medical facility sizes.

Table 12: Recommended Bandwidth Speeds for EHRs

Recommended Minimum Bandwidth Speeds	
Single Physician Practice	4 Mbps
Small Physician Practice (2-4 physicians)	10 Mbps
Nursing Home	10 Mbps
Rural Health Clinic (approximately 5 physicians)	10 Mbps
Clinic/Large Physician Practice (5-25 physicians)	25 Mbps
Hospital	100 Mbps
Academic/Large Medical Center	1,000 Mbps

Data Source: Health IT.gov
https://www.healthit.gov/providers-professionals/faqs/what-recommended-bandwidth-different-types-health-care-providers

The following table shows the percentage of county population that has access to 25Mbps network speed. The average statewide speed is 38.8 Mbps but this is misleading due to the imbalance between Arizona's urban and rural population distribution. For the purposes of EHR utilization, there are very high speeds for 80% of the population and very low speeds for the rural population. As you can see from the chart below, not all counties have access to broadband network speeds to support a large physician practice at 25 Mbps. This could impact FQHC's that operate in rural areas and Critical Access Hospital's.

(Section A.2 Continued – Internet Access Challenges to Rural Areas)

Table 13: Percentage of County Population with Broadband Speeds at 25 Mbps

Percentage of County Population With Broadband Speeds at 25 Megabits Per Second (Mbps)		
County	**Population**	**Broadband Speed @ 25 mbps**
Apache	71,518	6.5%
Cochise	131,346	75.5%
Coconino	116,320	54.1%
Gila	53,597	59.7%
Graham	37,220	76.3%
Greenlee	8,437	60.5%
La Paz	20,489	24.6%
Maricopa	3,817,117	97.6%
Mohave	200,186	73.2%
Navajo	107,449	49.9%
Pima	980,263	93.1%
Pinal	375,770	75.1%
Santa Cruz	47,420	84.0%
Yavapai	211,033	79.6%
Yuma	195,751	22.8%

Data Source: Arizona Association of Counties and Broadband Now
http://broadbandnow.com/Arizona , July 2016

Broadband Grants Received

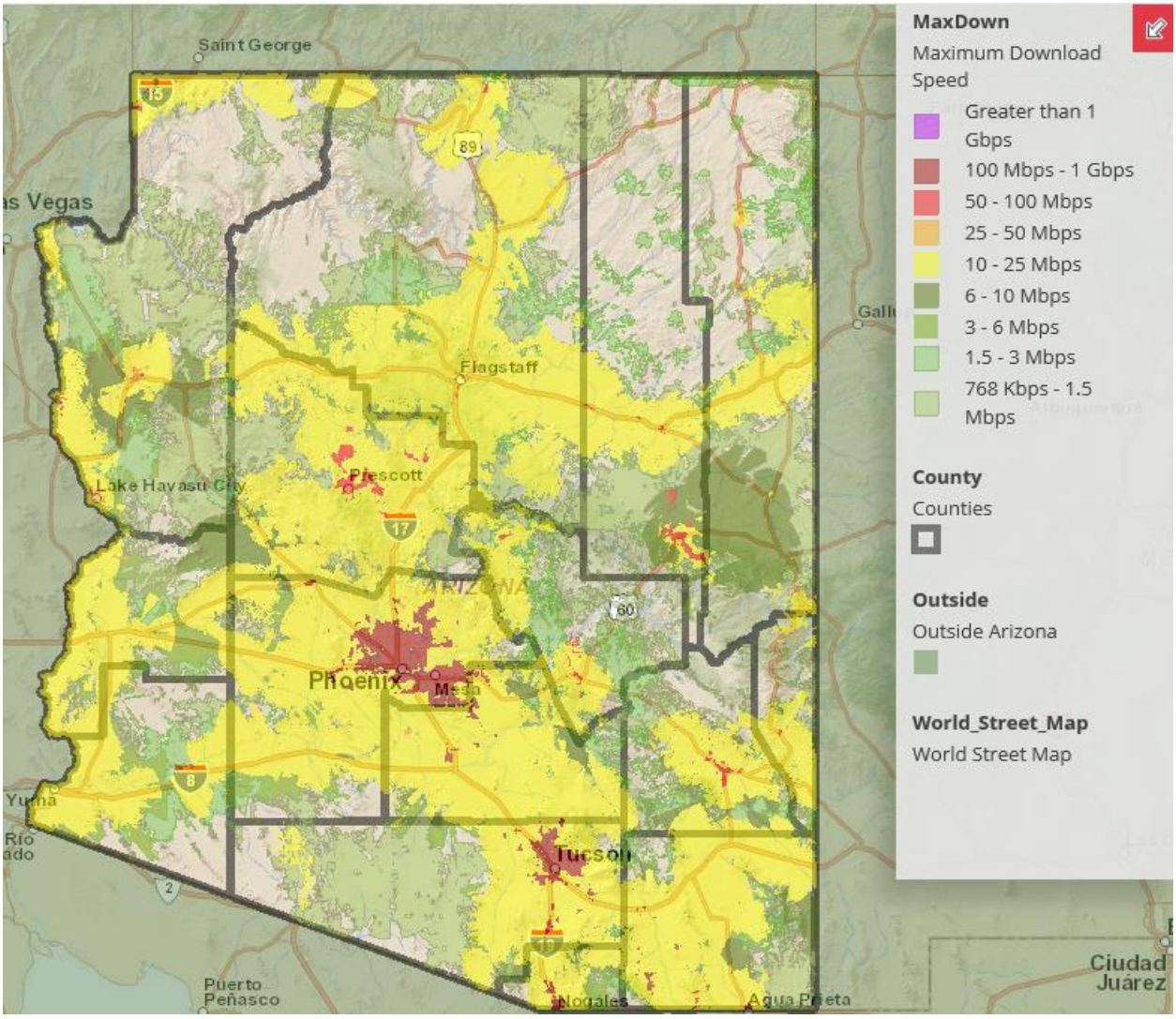
In preparation for this SMHP submission, AHCCCS contacted the Arizona Strategic Enterprise Technology (ASET) office of the Arizona Department of Administrative Services. This organization is responsible for development of bandwidth growth throughout the state. There are currently no grant funded initiatives or plans for the development of bandwidth in rural portions of the state. As mentioned above, AHCCCS has been invited to participate in future ASET planning activities.

Broadband Availability

According to the figure below, Arizona has communities that experience a range of broadband speeds. The speeds range from 1.5 Mbps to greater than 1 Gbps.

(Section A.2 Continued – Internet Access Challenges to Rural Areas)

Figure 8: Arizona Broadband Speed Map by County



Data Source: Arizona Strategic Enterprise Technology, 2015
http://broadbandmap.az.gov/broadbandapp/Viewer.aspx#ajax/map.html

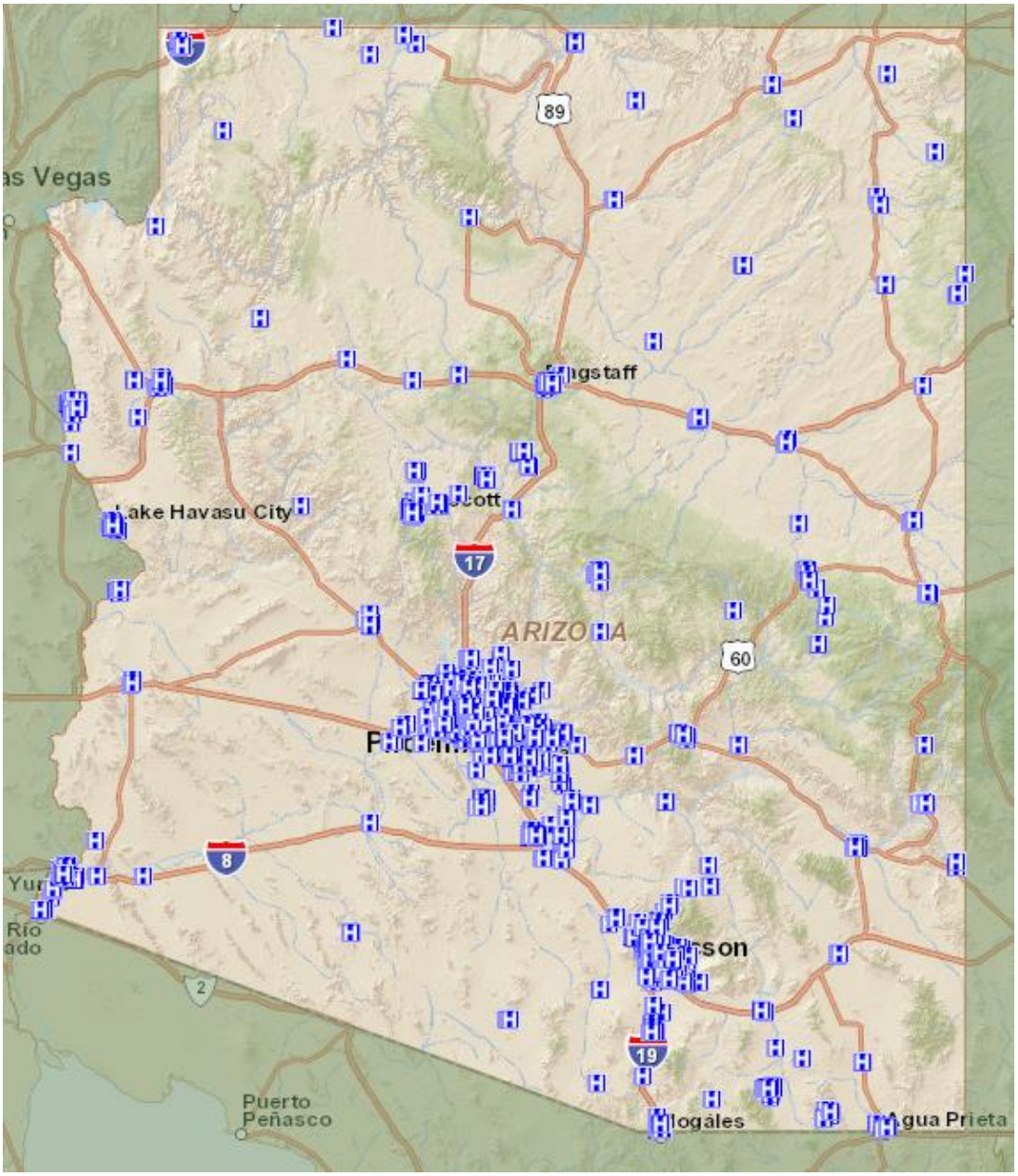
Broadband Availability and Hospital/Clinic Location

A comparison of the broadband speed coverage map (above) to the healthcare provider distribution figure (below) shows both Hospitals and Clinics in areas that could be experiencing problems in implementing HIT systems.

While the heaviest concentration of Hospitals and Clinics are in Phoenix and Tucson metro areas, which have adequate broadband coverage, lower broadband speeds are shown in the rural areas resulting in challenges to implementation and use of robust health IT systems.

(Section A.2 Continued – Internet Access Challenges to Rural Areas)

Figure 9: Arizona Hospital and Clinic Locations Requiring Broadband



Data Source: All Broadband Speed Heat maps This Section - Arizona Strategic Enterprise Technology ASET), 2015 (http://broadbandmap.az.gov/broadbandapp/#ajax/map.html)

A.3 FQHC HIT/HIE HRSA Grant Funding

(SMHP Companion Guide Question A #3)

HRSA Grant Funding

AHCCCS has reviewed the FQHC grant abstracts on the HRSA website for Arizona FQHCs for 2015 and 2016. There are none directly related to HIT/HIE grants. AHCCCS is not aware of any HIT related grants or funding opportunity announcements that have been made from HRSA to FQHC organizations inside Arizona. The only Health IT grants that had been received prior were from 2012 and were awarded to Federally Qualified Health Centers.

Participation and payment of FQHCs/RHCs eligible professionals in the EHR Incentive Program is detailed in the following paragraph and the accompanying table.

Since the last SMHP in 2015, the agency has lost one FQHC from its list of eligible participating FQHCs. This brings the total of FQHCs to 24. Nine-teen of the twenty-four FQHCs (79 percent) have eligible professionals (EPs) that have received EHR incentive payments as of September, 2016. Six of the nine RHCs (66 percent) have EPs that have received incentive payments in that same time period.

As of September, 2016, AHCCCS has paid over 1378 EPs in FQHCs for participation in the EHR Incentive Program. In that same time period, it has made payments to 60 EPs practicing in RHCs.

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Table 14: EPs in FQHCs and RHCs Receiving Medicaid EHR Incentive Program Payments

Federally Qualified Health Centers:

No.	FQHC/RHC Facility Legal Business Name	dba (Alternate Organization Name)	Facility Type	Attest	Payment	Number of EPs	Payment Years					
							1	2	3	4	5	6
1	Adelante Healthcare, Inc.		FQHC	✓	✓	60	25	21	14			
2	Ajo Community Health Center dba Desert Senita Community Health Center	Desert Senita Community Health Center	FQHC	✓	✓	6	6	0	0			
3	Canyonlands Community Healthcare		FQHC	✓	✓	16	16	0	0			
4	Chiricahua Community Health Centers, Inc. dba Business Office		FQHC	✓	✓	22	22	0	0			
5	Circle the City *(FQHC effective 06.15.2015)*		FQHC	×		0	0	0	0			
6	County of Yavapai DBA Yavapai County Community Health Services	Yavapai County Community Health Services	FQHC	✓	✓	23	15	8	0			
7	El Rio Santa Cruz Neighborhood Health Center		FQHC	✓	✓	349	175	106	68			
8	Healthcare for the Homeless dba Maricopa County Health Care for the Homeless	Maricopa County Health Care for the Homeless	FQHC	✓	✓	1	1	0	0			
9	Horizon Health and Wellness, Inc. *(formerly Mountain Health and Wellness)*		FQHC	✓	✓	14	11	2	1			
10	Marana Health Center Inc.		FQHC	✓	✓	54	48	6	0			
11	Maricopa County Special Health Care District dba Maricopa Integrated Health System	Maricopa Integrated Health System	FQHC	✓	✓	368	207	116	45			
12	Mariposa Community Health Center		FQHC	✓	✓	30	14	11	5			
13	Mountain Park Health Center		FQHC	✓	✓	162	89	50	23			

14	Native American Community Health Center, Inc. dba Native Health	Native Health	FQHC	✓	☐	0	0	0	0			
15	Native Americans for Community Action, Inc.		FQHC	×	☐	0	0	0	0			
16	Neighborhood Outreach Access to Health	Formerly Scottsdale Healthcare Hospitals dba Family Practice Center	FQHC	✓	✓	13	10	3	0			
17	North Country Healthcare Inc.		FQHC	✓	✓	118	72	37	9			
18	St. Elizabeth's Health Center *(FQHC effective 04.01.2015)*		FQHC	✓	✓	5	4	1	0			
19	Sun Life Family Health Center, Inc. dba Sun Life Family Health Center	Sun Life Family Health Center	FQHC	✓	✓	28	23	5	0			
20	Sunset Community Health Center		FQHC	✓	✓	64	40	16	8			
21	Terros, Inc. *(FQHC effective 04.01.2015)*		FQHC	×	☐	0	0	0	0			
22	United Community Health Center Maria Auxilladora Inc.	Continental Family Med.	FQHC	✓	✓	42	25	12	5			
23	Valle Del Sol, Inc. *(FQHC effective 04.01.2015)*		FQHC	×	☐	0	0	0	0			
24	Wesley Community Center Inc.		FQHC	✓	✓	3	3	0	0			
						1,378	806	394	178	0	0	0

Rural Health Centers:

No.	FQHC/RHC Facility Legal Business Name	dba (Alternate Organization Name)	Facility Type	Attest	Payment	Number of EPs	Payment Years					
							1	2	3	4	5	6
1	Bisbee Hospital Association dba Copper Queen Community Hospital	Copper Queen Community Hospital	RHC	✓	✓	38	21	12	5			
2	Cobre Valley Regional Medical Center	Cobre Valley Community Hospital	RHC	✓	✓	3	3	0	0			
3	Community Hospital Association Inc. dba Wickenburg Community Hospital	Wickenburg Community Hospital	RHC	×		0	0	0	0			
4	La Paz Regional Hospital, Inc. dba La Paz Regional Hospital	La Paz Regional Hospital	RHC	✓	✓	3	2	1	0			
5	Mount Graham Regional Medical Center dba Copper Mountain Clinic	Copper Mountain Clinic	RHC	×		0	0	0	0			
6	Northern Cochise Community Hospital Inc.		RHC	×		0	0	0	0			
7	Parker Medical Center, LTD *(RHC effective 12.14.2015)*		RHC	✓	✓	1	0	0	1			
8	San Luis Walk In Clinic, Inc.		RHC	✓	✓	13	7	6	0			
9	Summit Healthcare Association dba Summit Healthcare Specialty Physicians	Summit Healthcare RMC	RHC	✓	✓	2	2	0	0			
						60	35	19	6	0	0	0

Data Source: AHCCCS EHR Team September, 2016

A.4 VA and IHS Operation of Electronic Health Records

(SMHP Companion Guide Question A #4)

Veterans Administration (VA) and Indian Health Services (IHS) EHR Adoption and Health Information Exchange Connectivity

(Section A.4 Continued)

Veterans Administration (VA) Facilities EHR Adoption and Health Information Exchange Connectivity

The VA operates three campuses with multiple clinical facilities in Arizona. The VA is currently participating in the Federal Health Architecture Work Plan and is using The eHealth Exchange (formally NwHIN Exchange and an initiative of The Sequoia Project) as its required transport for health data. All state HIEs must meet eHealth Exchange requirements before VA data will be made available to any other HIE. The Arizona Health-e Connection has received eHealth Exchange certification and can accept messages and exchange with approved federal partners including the VA and Social Security Administration (SSA).

The state level HIE (The Network) run by Arizona Health-e Connection has received eHealth Exchange certification with its new technology platform, Mirth. AzHeC is leading outreach efforts to the VA to secure their participation in the Arizona HIE network. The largest VA campus is in Phoenix which is a clinical Level 1 facility and which provides acute medical, surgical and psychiatric inpatient care as well as rehabilitation medicine, and neurological care. There are two other campuses – one in Prescott Arizona (Northern area) and a campus in Southern Arizona in Tucson.

Indian Health Service EHR Adoption and Health Information Exchange Connectivity

Current Indian Health Service HIT/HIE Initiatives - Arizona is home to over 250,000 American Indians, approximately half of whom are enrolled in AHCCCS. AHCCCS covers over 50 percent of all American Indian births, and more than two-thirds of all nursing facility days utilized by American Indians in Arizona. The IHS, tribal health programs operated under P.L. 93-638, and urban Indian Health Programs (collectively referred to as I/T/U) are the primary providers of health care to the majority of the estimated 126,000 American Indians enrolled in the AHCCCS program as of April 2013. Three IHS Area Offices oversee a number of hospitals and health care centers in the state of Arizona. There are approximately 12 medical hospitals and health centers that are tribal health programs operated under P.L. 93-638. Additionally, there are a number of behavioral health programs operated under P.L. 93- 638 among the 22 tribes in Arizona. Three urban Indian health programs oversee four health centers that are located in the urban centers of the state – Phoenix, Tucson, and Flagstaff.

(Section A.4 Continued)

Indian Health Service Electronic Health Record

All of the IHS clinical facilities use the Resource and Patient Management System (RPMS) as their EHR system and have attested for Stage 1 of MU. RPMS is an integrated solution for the management of clinical, business practice and administrative information in healthcare facilities of various sizes. The RPMS has an ambulatory EHR, which most, if not all, facilities use. The RPMS also has an inpatient and emergency room component, which may be used by some IHS Facilities. The balance of the tribal sites use commercial EHR systems. Certain tribal health programs operated under P.L. 93-638 including urban Indian health programs may also use the RPMS.

RPMS is 2011 certified and has received 2014 certification Incorporated within the upgrade are provisions for the Continuity of Care Document Architecture that will enable the ability to communicate to the national eHealth Exchange, the Personal Health Record and Direct Messaging. The Phoenix and Navajo Area deploy the EHR to servers with-in the facilities while the Tucson Area is using an integrated EHR server for their Clinics. To our knowledge, Indian Health Services is not participating in health information exchange yet with other organizations.

The table below is a summary, by IHS Region, of the HIT activity in Arizona.

Table 15: Arizona EHR Live Sites: Indian Health Service Active Site Listings

Usage Key:
IP = Inpatient Utilization
eRx = ePrescribing Utilization
VI = VistA Imaging Utilization
BCMA = Bar Code Medication Administration

Navajo Area (15)					
Facility Name	**City**	**State**	**Type**	**Affiliation**	**Usage**
Hospitals					
Tsehootsooi Medical Center	Fort Defiance	AZ	Hospital	Tribal	IP, VI, BCMA
Chinle Comprehensive Health Care Center	Chinle	AZ	Hospital	IHS	IP, VI
Clinics					
Nahata Dzile Health Center	Sanders	AZ	Clinic	Tribal	
Tsaile Health Center	Tsaile	AZ	Clinic	IHS	VI
Pinon Health Center	Pinon	AZ	Clinic	IHS	VI

Kayenta Health Center	Kayenta	AZ	Clinic	IHS	VI
Inscription House Health Center	Shonto	AZ	Clinic	IHS	VI
Winslow Health Center	Winslow	AZ	Clinic	Tribal	VI
Four Corners Regional Health Center	Red Mesa	AZ	Clinic	IHS	VI
Dzilthnahodilthe Health Center	Dzithnahodilthe	AZ	Clinic	IHS	

Phoenix Area 32					
Facility Name	**City**	**State**	**Type**	**Affiliation**	**Usage**
Hospitals					
Hu Hu Kam Memorial Hospital	Sacaton	AZ	Hospital	Tribal	IP, VI
Whiteriver Indian Hospital	Whiteriver	AZ	Hospital	IHS	IP, VI
Hopi Indian Hospital	Polacca	AZ	Hospital	IHS	IP, VI
Phoenix Indian Medical Center	Phoenix	AZ	Hospital	IHS	IP
Parker Indian Hospital	Parker	AZ	Hospital	IHS	IP,VI
San Carlos IHS Indian Hospital	San Carlos	AZ	Hospital	IHS	VI, IP
Clinics					
Gila Crossing Clinic	LaVeen	AZ	Clinic	Tribal	VI
Ak Chin Clinic	Maricopa	AZ	Clinic	Tribal	VI
Cibecue Health Center	Cibecue	AZ	Clinic	IHS	
West End Health Center	Yavapai	AZ	Clinic	Tribal	
Salt River Reservation Clinic	Scottsdale	AZ	Clinic	Tribal	
Peach Springs Indian Health Center	Peach Springs	AZ	Clinic	IHS	
Supai Health Station	Supai	AZ	Clinic	IHS	
Wassaja Memorial Health Center	Fort McDowell	AZ	Clinic	Tribal	
Fort Yuma Service Unit	Yuma	AZ	Clinic	IHS	VI
Bylas Health Center	Bylas	AZ	Clinic	IHS	
Ft Mojave Health Center	Mojave Valley	AZ	Clinic	Tribal	
Native American Community Health Center	Phoenix	AZ	Clinic	Urban	eRx
Native American Community Health Dunlap	Phoenix	AZ	Clinic	Urban	

Tucson Area 4					
Facility Name	**City**	**State**	**Type**	**Affiliation**	**Usage**
Hospitals					
Sells Indian Hospital	Sells	AZ	Hospital	IHS	IP, VI
Clinics					
Santa Rosa Health Center	Santa Rosa	AZ	Clinic	IHS	VI
San Xavier Health Center	Tucson	AZ	Clinic	IHS	VI
San Simon Health Center	San Simon	AZ	Clinic	IHS	VI

Updated 07/26/2016

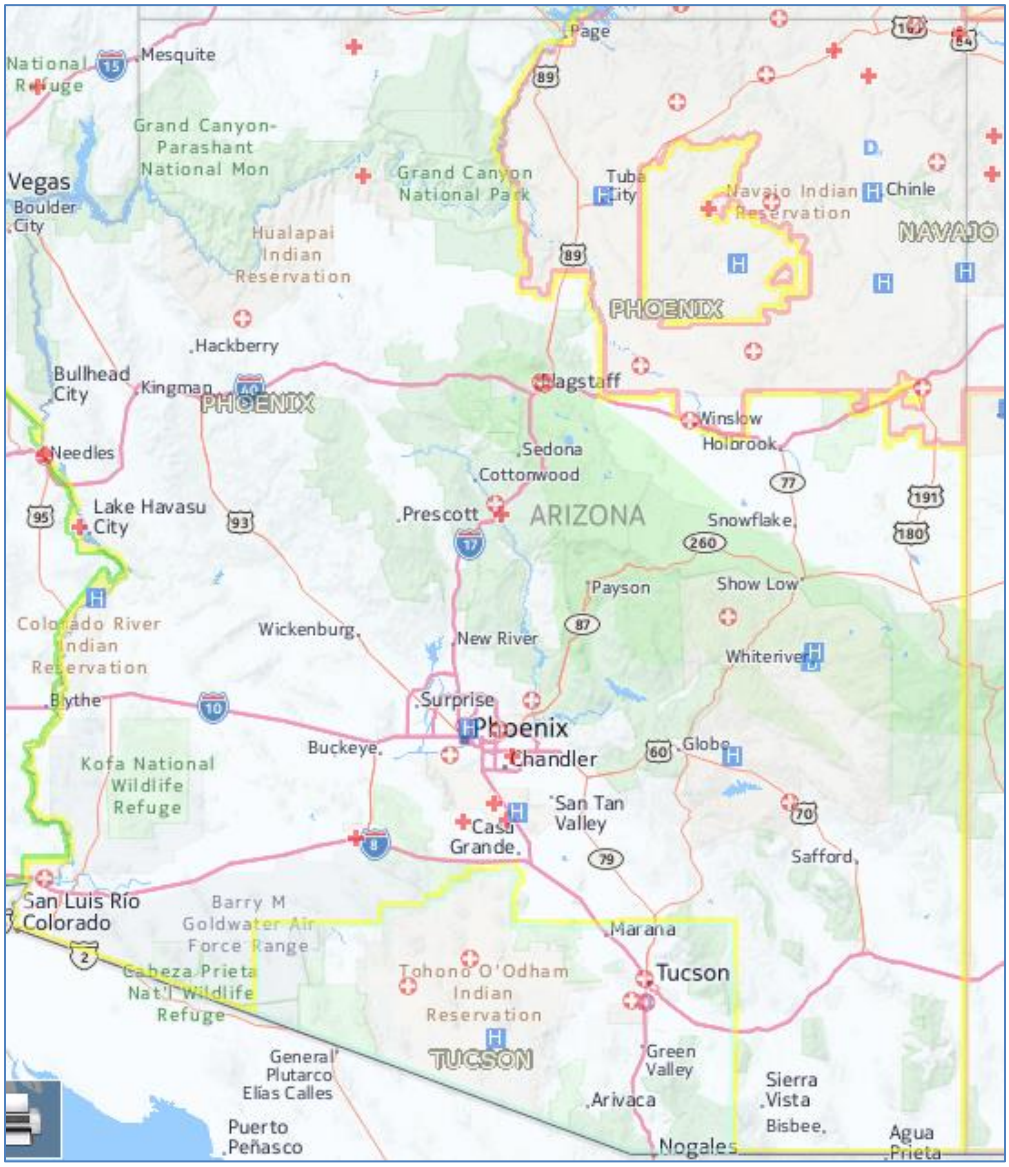
Data Source: Indian Health Service (http://www.ihs.gov/ehr/index.cfm?module=gui_facilities)

Continuity of Care Document Architecture

Regarding Continuity of Care Document Architecture enabling IHS to communicate to the national eHealth Exchange, The Network (State Level HIE) has communicated with IHS. IHS has indicated that their focus was to connect to other federal agencies and departments before they established connectivity with non-federal organizations. Establishing connectivity to the Arizona HIE/The Network is not currently a part of the IHS Document Architecture plan for this year.

The map below identifies the location of IHS health care facilities in Arizona, by service type.

Figure 10: Indian Health Services Healthcare Facilities



Data Source: IHS, 2016 https://mapapp.ihs.gov/healthfacilities/

- Other (23)
- Hospital (6)
- Behavioral Health Facility (2)
- Health Center (21)
- Health Station (22)

(Section A.4 Continued)

Summary of Arizona's Behavioral Health System for Discussion of State Run Psychiatric Health Facilities

Existing Medicaid Behavioral Health Infrastructure: Arizona only has two state run psychiatric hospitals, the Arizona State Hospital and the Arizona State Forensic Hospital. There are sixteen other psychiatric hospitals in the state but they are not managed by the state of Arizona.

There are 520 licensed behavioral health facilities which include:

- Behavioral Health Inpatient Residential Treatment Centers
- Behavioral Health Residential Facilities for Adults and Children
- Inpatient Residential Treatment Centers Subacute Facilities
- Behavioral Health Respite Home
- Hospital - Psychiatric

Behavioral health services have, until recently, been carved out or separate from the Medicaid managed care contracts in Arizona. Organizations called Regional Behavioral Health Authorities (RBHAs) contract with the Division of Behavioral Health Services (DBHS) in the Department of Health Services to manage and provide public behavioral health services in a given geographic service area through a network of providers, clinics, and other facilities.

Effective July 2016, the two state agencies merged under AHCCCS to promote efficiencies, reduce costs and allow for more coordinated contract oversight of the Regional Behavioral Health Authorities (RHBAs).

Vehicle for Medicare-Medicaid Integration: Almost all Medicaid beneficiaries are enrolled in managed care for Medicaid physical health and Long Term Support Services (LTSS). Since 2006, Arizona has pursued an integrated delivery system for Medicare-Medicaid beneficiaries through a Dual Eligible Special Needs Plan (D-SNP) contracting platform by encouraging individuals to enroll in the same plan for Medicare and Medicaid services. Arizona recently required participating Medicaid MCOs to qualify as a D-SNP in all the various geographical areas where they have a Medicaid contract to offer the opportunity for all dually eligible beneficiaries to enroll in aligned plans.

Approach to Integrating Behavioral Health: Since 2014, AHCCCS launched a new program to provide integrated behavioral health services in Maricopa County. Merging its RBHA and D-SNP platforms, the state awarded a contract to Mercy Maricopa Integrated Care (MMIC) to serve as the Maricopa County RBHA. MMIC will deliver and coordinate all Medicaid behavioral and physical health services for Medicaid beneficiaries who have serious mental illness (SMI) in Maricopa County, including those dually enrolled in Medicare. MMIC is a D-SNP, an Arizona requirement for this procurement. Medicare-Medicaid beneficiaries may choose to receive Medicare-covered services through MMIC to achieve fully aligned health care through one organization. MMIC is responsible for all services; it may not subcontract any key health plan

operations that are critical to the integration of behavioral and physical health care, including Medicare services.

As of October 1 of 2015, Medicaid behavioral and physical health services for Medicaid beneficiaries who have SMI will extend to greater Arizona and will include a statewide crisis delivery system. Services in northern Arizona will be facilitated by (HCIC) Health Choice Integrated Care and in the south, by (CIC) Cenpatico Integrated Care.

This new RBHA arrangement tested by MMIC introduces more comprehensive requirements for care coordination and management. These requirements are designed to improve care for all enrolled individuals and offer particular benefits for individuals with SMI who are dually eligible for Medicare and Medicaid, such as:

- **Care coordination** at the system and provider levels across physical and behavioral health providers for Medicaid and Medicare benefits to directly manage the treatment team and ensure cross-specialty collaboration and care management;
- **Processes for targeting inventions for high-risk beneficiaries**, such as identification of and monitoring of cases for the top 20 percent of high-risk/high-cost beneficiaries with SMI and new tools for risk assessments and predictive modeling;
- **Prevention strategies** that reduce the incidence and severity of serious physical and mental illness;
- **Enhanced discharge planning** and follow-up care between provider visits; and
- **Health information technology** to promote physical and behavioral systems integration, and house linked Medicare-Medicaid data and a stratified patient registry to identify the highest risk beneficiaries.

A.5 Stakeholder Engagement in HIT/HIE Activity

(SMHP Companion Guide Question A #5)

Stakeholder Involvement in HIT/HIE - In 2006, Arizona published it's first HIT/HIE roadmap the "Arizona Health-e Connection Roadmap" (referred to as *Roadmap 1.0*). This broad-based engagement produced not only a roadmap but also an organizational structure called, Arizona Health-e Connection (AzHeC). Medicaid was a very active participant and supported the creation of AzHeC which is a public/private partnership and nonprofit organization that drives the adoption and optimization of HIT/HIE.

Since its inception AHCCCS and 6 other organizations have been permanent members on the AzHeC board to facilitate state support and planning for information technology and exchange. The SMA sits on the Arizona Health-e Connection Board only; the agency does not sit on any other HIE or Regional HIE board. A full listing of AzHeC Board Members, showing the diversity of their representation is detailed in the table below.

Table 16: Arizona Health-e Connection Board of Directors May 2016

Arizona Health-e Connection
Advancing health and wellness through information technology

2016 Board of Directors

	Board Allocation	Board Organization	Board Member
Permanent Members	The Governor of Arizona	Governor's Office	Christina Corieri, Policy Advisor Health & Human Services
	Arizona Health Care Cost Containment System (AHCCCS)	AHCCCS	Thomas J. Betlach, Director
	Arizona Department of Health Services (ADHS)	ADHS	Janet Mullen, Deputy Director
	Arizona Department of Administration (ADOA)	ADOA	Vacant
	Arizona Hospital & Healthcare Association (AzHHA)	AzHHA	Greg Vigdor, President & CEO
	Arizona Medical Association (ArMA)	ArMA	Pele Peacock, Vice President, Policy & Political Affairs
	Arizona Osteopathic Medical Association (AOMA)	AOMA	Peter Wertheim, Executive Director
Non-Permanent Members	Health Plans	Blue Cross Blue Shield of Arizona	Garrett Anderson, Vice President & CTO
		Cenpatico Integrated Care	Sloane Steele, Sr. Vice President, Business Systems & Data Management
		Cigna	John Parente, MD, CMIO
		Mercy Care Plan	Mark Fisher, CEO
		UnitedHealthcare	Karen Saelens, COO, UHC Community Plan
	Hospitals	Abrazo Community Health Network	Michele Finney, CEO
		Banner Health	Ryan Smith, Senior VP & CIO
		Benson Hospital	Rob Roberts, IT Director
		Carondelet Health Network	Amy Beiter, MD, CEO, St. Mary's Hospital
		Dignity Health	Sean Turner, Sr. Director, Interoperability & Population Health
		HonorHealth	Richard Silver, MD, Senior VP, Population Health & Executive CMO
		Yavapai Regional Medical Center	Tim Roberts, CIO
	Higher Education Institution	Arizona State University	William G. Johnson, PhD, Professor, Biomedical Informatics
	Laboratory	Sonora Quest Laboratories	David Dexter, President & CEO
	Pharmacy	Arizona Pharmacy Association	Kelly Fine, CEO

Table 16: AzHeC Board of Directors (continued)

	At-Large	Arizona Alliance of Community Health Centers	John McDonald, CEO
		Arizona Health Care Association	Kathleen Collins Pagels, Executive Director
		Arizona Nurse Practitioners Council	Erich Widemark, PhD, Director of Simulation Education, University of Phoenix
		Cardiovascular Consultants	Andrei Damian, MD, President
		District Medical Group	Jeff Weil, CIO
		El Rio Community Health Center	Nancy Johnson, CEO
		Health Information Management Systems	Khalid Al-Maskari, CEO
		Health Services Advisory Group	Mary Ellen Dalton, CEO
		Independent Healthcare Consultant	Tony Fonze
		Maricopa County Correctional Health	Jeff Alvarez, MD, Director
		Mountain Park Health Center	Bill Kirkland, Data Manager
		Regional Center for Border Health	Philip Gladney, Director of Information Technology
		University of Arizona, College of Medicine	Ronald Weinstein, MD, Founding Director, Arizona Telemedicine Program

Data Source: Arizona Health-e Connection May 2016

AzHeC received both Regional Extension Center (REC) funding and HIE Cooperative Agreement funding from the ONC office, which expired at the beginning of 2014. AzHeC took the lead in gathering stakeholders to provide input into a new state Health IT Roadmap that was published in February 2014. The name of the most current Roadmap is ***Health IT Roadmap 2.0*** and is available for download here http://www.azhec.org/?page=HealthIT_Roadmap.

In the past Arizona Health-e Connection has been the lead organization in our state to engage external stakeholders and Medicaid stakeholders when community input is needed for developing Health IT/Health Information Exchange. AHCCCS has recently added contract language to its contracts with Medicaid Contracted Organizations (MCOs) requiring them to join Arizona's state level HIE operated by AzHeC.

AHCCCS has received CMS approval to use HITECH 90/10 funds to help incentivize Hospitals, FQHCs/RHCs and physician groups with Medicaid providers that have received a Medicaid EHR Incentive Payment to onboard with The Network for the purpose of improving care coordination, meeting MU measures and eventually achieve more robust clinical data sharing.

AzHeC is working with the Arizona Department of Health Services (ADHS) to include Public Health Reporting for the MU Program. ADHS is also a member of AzHeC's Board of Directors.

(Section A.5 Continued)

Private Accountable Care Organizations (ACOs)

There are a number of private HIEs, including those being developed by Accountable Care Organizations (ACOs) and other payer management organizations) that are forming across the state. AHCCCS has no governance relationship with any private HIE entities.

Stakeholder Incorporation in Meaningful Use – AHCCCS has leveraged its relationships with stakeholders to provide sustainable funding for HIE development, specifically in regards to onboarding of eligible hospitals, physician groups and FQHCs/RHCs to The Network.

Through this submission of the 2016 State Medicaid HIT Plan, AHCCCS is requesting permission to claim 90 percent HITECH match for HIE – related costs relating to Medicaid providers that are not eligible for Medicaid EHR Incentive payments only if those HIE related costs help Eligible Providers demonstrate Meaningful Use. (SMD#16-003)

A.6 SMA HIT/HIE Relationship with Other Entities

(SMHP Companion Guide Question A #6)

Stakeholder Engagement in HIT/HIE Activities

AHCCCS maintains an active and mutually supportive HIT/HIE relationship with multiple organizations and with our state level coordinating organization, Arizona Health-e Connection (AzHeC). Because of AzHeC's broad based representation on its board, its inclusiveness in its stakeholder engagement and the history of its work, AHCCCS works most closely with them as a public/private partnership to improve Health IT/HIE.

At the end of 2015, the Health Information Network of Arizona (HINAz) board dissolved and Arizona Health-e Connection became the sole operator and manager of the health information exchange platform. The HINAz Board became the Network Leadership Council.

SMA Relationships with Other HIT/HIE Entities

All of the organizations below are entities that the SMA has relationships with that include a focus for improving HIT/HIE. Some are at the county level, university level, or at the state government level.

AzHeC – Created by executive order, this non-profit provides statewide HIT/HIE expertise. AzHeC was selected by ONC to be the state REC and is the parent of the state level HIE. AHCCCS has selected AzHeC to conduct education and recruitment of non-participating EPs and EPs not progressing through Meaningful Use. AzHeC has absorbed the HINAz organization and all of its operations to create a single state level HIE for physical health and behavioral health providers.

ADHS – The Arizona Department of Health Services, Division of Public Health is coordinating its Health IT plans through AzHeC to ensure it can meet MU and eventually move to population health reporting and analytics.

ASU/CHiR – The SMA contracts with Arizona State University Center for Health Information Research (CHIR) conducts an annual environmental scan of all licensed state physicians in cooperation with the Arizona Board of Medical Examiners to assess physician adoption of EHR Technology.

ASET - The Medicaid HIT Coordinator who also is the State HIT Coordinator has worked with the Arizona Strategic Enterprise Technology (ASET) under the Office of the National Coordinator's past grant funding to enhance HIT adoption and to accelerate HIE connectivity and interoperability among a broad spectrum of providers. (Statewide impact is through cross agency coordination of HIT/HIE.)

DOC – Arizona Department of Correction's contracted service provider (Corizon) has informed AHCCCS (since the last SMHP) that it will not be pursuing participation in the EHR Incentive Program.

IHS- Indian Health Services, AHCCCS works closely through its Division of Fee for Service Management (DFSM) and through the HIE, with IHS to ensure it is going to be able to send and receive clinical data for its Fee For Service Members and exchange with its federal partner. The SMA has created an interface with The Network to view clinical data for its American Indian Health Program participants.

MCC – Maricopa County Corrections is working with AHCCCS to determine how their EPs and CEHRT can successfully participate in the EHR Incentive Program.

MCOs – As part of their contractual requirements for serving as a Medicaid Managed Care Organization (MCOs), AHCCCS has asked that Managed Care Organizations be participants in The Network. MCOs and Hospitals provide funding to The Network to support its ongoing operations.

PCC- Pima County Corrections is also working with AHCCCS to determine how their EPs and CEHRT can successfully participate in the EHR Incentive Program

PCPH -Pima County Public Health Department - This county public health department has been working with AHCCCS for several months to determine if it can qualify for the EHR Incentive Program.

(Section A.6 Continued)

SMA HIT/HIE Entity Relationships and State Goals for MU Capabilities and HITECH Systems

AHCCCS is using its relationships with its stakeholders (above) to develop strategies that will be able to accept more reporting and data from its registered providers electronically and in real time. Currently the agency receives claims and encounter information but does not receive clinical information. AHCCCS has 4 strategic priorities .

1) Bending the Cost Curve While Improving the Member's Health Outcomes

2) Pursuing Continuous Quality Improvement

3) Reducing Fragementation in Healthcare Delivery to Develop an Integrated System of Healthcare and

4) Maintaining a core organizational capacity, infrastructure and workforce

These goals require the agency to accelerate the delivery system's evolution towards a value-based integrated model that focuses on whole person health throughout the continuum and in all settings, and each of the components of the Arizona strategy will improve population health, transform the health care delivery system and/or decrease per capita health care spending.

Relationships with The Network, the Arizona Department of Health Services/Public Health, Indian Health Services, the Veterans Administration, the Managed Care Contractors and RHBAs are all being coordinated to support more timely clinical data sharing among providers and more comprehensive patient information to support better care outcomes.

Plans to Improve HIT/HIE Entity Relationships

The SMA communicates frequently with all of its stakeholders to ensure it is communicating its vision and priorities and provides resources if possible to ensure its providers can be successful in adopting and implementing health IT and reaching MU milestones. The agency is transparent in its dealings with all participants.

One vehicle for SMA communication with stakeholders is its permanent seat on the Board of Directors of the Arizona Health-e Connection. A demonstration of the variety of stakeholder relationships is provided in Table 16 (above).

Through its participation as a permanent member of the Board of Directors for AzHeC, AHCCCS has an opportunity to expand relationships with organizations that have a broad and shared interest in a number of those HIT/HIE subject areas. The figure below provides a graphic representation of some of those organization types.

(Section A.6 Continued)

Figure 11: Collaboration of HIT/HIE Community Resources

Data Source: Arizona Health-e Connection

Comparison of Arizona to Other States for Electronic Sharing of Information in Physician Offices

The CDC/National Center for Health Statistics recently published a report “State Variation in Electronic Sharing of Information In Physician Offices: United States, 2015”. The report uses the 2015 National Electronic Health Records Survey (NEHRS) to describe the extent to which physicians can electronically send, receive, integration, and search for patient health information.

(Section A.6 Continued)

Key Findings from the Report show that:

- In 2015 the percentage of physicians who had electronically sent patient health information ranges from 19.4% in Idaho to 56.3% in Arizona
- In 2015, the percentage of physicians who had electronically received patient health information ranged from 23.6% in Louisiana and Mississippi to 65.5% in Wisconsin.
- In 2015, the percentage of physicians who had electronically integrated patient health information from other providers ranged from 18.4% in Alaska to 49.3% in Delaware
- In 2015, the percentage of physicians who had electronically searched for patient health information ranged from 15.1% in the District of Columbia to 61.2% in Oregon.

The table below shows how the State of Arizona compares to the National percentage for each of the four key measures.

Table 17: Arizona Ranking to National Averages in Physician Sharing

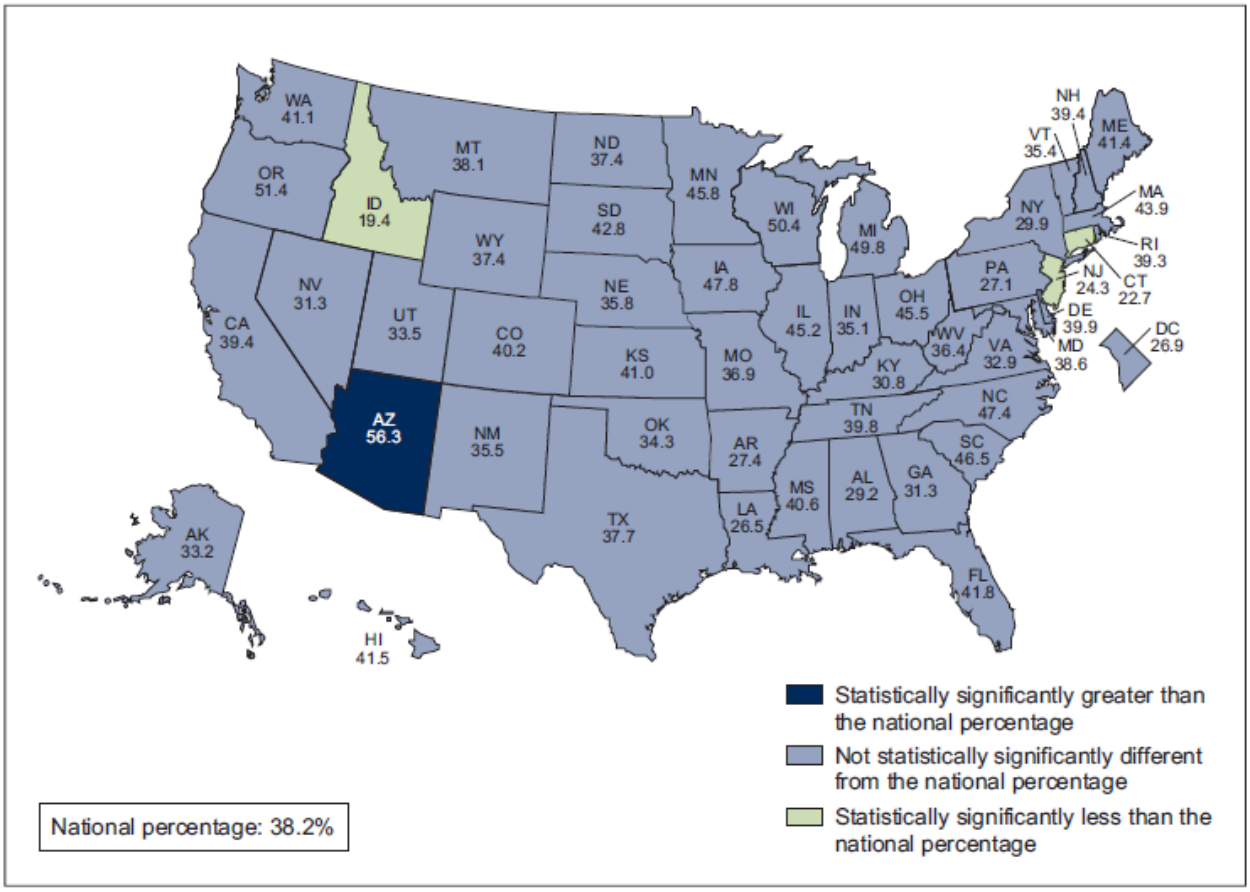
NCHS Data Brief: State Variation in Electronic Sharing in Physician Offices (2015)		
Data Measure	**National Percentage**	**Arizona Percentage**
Percentage of Physicians that electronically sent patient health information to other providers.	38.2%	56.3%
Percentage of office based physicians who received patient health information from other providers	38.3%	40.6%
Percentage of office based physicians who electronically integrated patient health information from other providers	31.1%	44.1%
Percentage of office based physicians who electronically searched for patient health information from other providers	34%	37.6%

Data Source: CDC, National Center for Health Statistics, November, 2016

The map below is a snapshot showing Arizona as the only state that was identified as having been “statistically significantly greater than the national percentage” for the measure of physicians who sent patient health information electronically to their providers.

(Section A.6 Continued)

Figure12: Percentage of Office- based physicians who sent patient health information electronically to other providers by state: United States 2015



NOTES: Significance tested at $p < 0.05$. Access data table for Figure 2 at: http://www.cdc.gov/nchs/data/databriefs/db261_table.pdf#2.
SOURCE: NCHS, National Electronic Health Records Survey, 2015.

A.7 Health Information Exchange Governance Structure

(SMHP Companion Guide Question A #7)

The AzHeC board is comprised of 35 organizational representatives which includes the Director of the SMA. AzHeC serves as our statewide governance entity for HIT/HIE. Since AzHeC started in 2006-2007, there have been 7 state wide permanent members on the AzHeC Board including:

- The AHCCCS Director
- The ADHS Director
- The ASET Director

- The Arizona Governor's Office Representative
- Arizona Hospital and Health Care Organization (AzHHA)
- The Arizona Medical Association and
- Arizona Osteopathic Medical Association

Since 2013, AzHeC has been overseeing the Health Information Network of Arizona (HINAz), a separate organization that had operational responsibility for running the statewide HIE operations. Both organizations merged in December 2015 to achieve operational efficiencies and economies of scale.

Board Composition - The AzHeC board members are recruited from across the state and oversee all functions of this non-profit organization. The board is a state level board and has a statewide geographic scope representing the following areas:

- Hospitals
- Health Plans
- Universities
- Employers
- Large Reference Laboratories (i.e. Sonora Quest)
- Other state government representatives including the Governor's Health Policy Advisor
- Community Health Centers
- Physicians
- Nurses
- Pharmacy
- Behavioral Health
- Long Term Care
- Quality Innovation Network (QIN) – Quality Improvement Organization (QIO)

Board Function - The board and the staff are involved in HIT/HIE activities including recruitment for The Network to get more participants to join the HIE, they assist with recruiting providers to receive services from the Regional Extension Center, they support the annual education and outreach conference hosted by AzHeC, they oversee the funding of the education program and The Network by approving an annual budget.

(Section A.7 Continued)

The former Board of HINAz became the Network Leadership Council (NLC). Its composition is detailed in the table below and the purpose of the NLC is to provide information technology expertise and oversight to The Network. AHCCCS is adding its Chief Information Officer to the Network Leadership Council in December, 2016.

Table 18: Network Leadership Council

Arizona Health-e Connection
The Network

2016 Network Leadership Council

Organization	Board Member
Banner Health	Geoff Duke, VP, Clinical Applications
Care1st Health Plan Arizona	Scott Cummings, CAO
Dignity Health	Sean Turner, Senior Director, HIE / Community Care
Health Choice Arizona	Troy Garland, Vice President, Clinical Services
Marana Health Center	Clint Kuntz, Chief Executive Officer
Maricopa Integrated Health System	Kelly Summers, Chief Information Officer
Mercy Care Plan & Mercy Maricopa Integrated Care	Christi Lundeen, Chief Innovation Officer
New Pueblo Medicine	Mike Cracovaner, Chief Executive Officer
Northern Arizona Healthcare	Marilynn Black, Chief Information Officer
Partners In Recovery	Christy Dye, President & CEO
Pima County	Francisco Garcia, MD, Medical Director
Sonora Quest Laboratories	David A. Dexter, President & CEO
TMC HealthCare	Frank Marini, VP & CIO
UnitedHealthcare	William H. Hagan, Chief Growth Officer
Yuma Regional Medical Center	Fred Peet, Chief Information Officer

Data Source: Arizona Health-e Connection August, 2016

(Section A.7 Continued)

Current Plans to use HIE to meet MU and how HITECH Systems will Achieve State Health Goals

In addition to the AHCCCS priorities and goals for HIT and HIE, AHCCCS also worked with other HIT stakeholders to help develop the *Arizona HIT Roadmap 2.0* which sets the statewide goals for adoption and implementation of technology through 2019.

Overall *Roadmap 2.0* identifies three essential strategies that will guide the continued adoption and advancement of HIT/HIE in Arizona. To be successful, the statewide community wanted to:

- Continue to support physicians and other providers in their adoption and use of technology
- Accelerate and expand the secure sharing of health information among health care providers and
- Continue to coordinate and convene health care stakeholders to develop strategies that meet evolving HIT/HIE business needs

Arizona's Health IT Roadmap 2.0 describes 19 key initiatives to advance HIT/ HIE recommending action in areas ranging from stakeholder engagement and policy development to technology infrastructure implementation, and exploration of innovative technology models that support care delivery transformation. Roadmap 2.0 is found on the AzHeC website and downloaded from: http://www.azhec.org/?page=HealthIT_Roadmap

These are the 19 key initiatives that were described in the roadmap and are displayed here:

Stakeholder Engagement & Participation

01 - **Stakeholder Engagement and Collaboration**

Continues current, and develops and implements new, programs that promote statewide multi-stakeholder engagement and collaboration.

02 - **Stakeholder Information and Education**

Continues current, and develops and implements new, HIT/HIE educational and outreach programs for the various health care stakeholder segments.

Governance, Policy, & Planning

03 - **Statewide Governance of Health Information Exchange**

Refines and clearly describes the roles, responsibilities, and accountabilities of the AzHeC and HINAz boards and the State of Arizona related to statewide HIT/HIE within the public/private partnership governance model.

04 - **Interoperability and Content Standards Agreement and Adherence**

Ensures that Arizona uses HIT/HIE interoperability and content standards for the exchange of health care information.

05 - **Statewide Unique Patient Identifier**

Explores the feasibility for alternative approaches for identifying a patient.

06 - **Incentives to Support Continued Expansion of HIT/HIE**

Builds upon current programs for incenting providers to adopt HIT and participate in HIE. Explores and identifies innovative ways to incent providers to continue to adopt and/or mature their use of HIT/HIE.

07 - **Collaboration and Support for Broadband Access**

Coordinates information on broadband access assistance available to health care providers

08 - **Influence HIT and HIE Vendors**

Develops an approach to help Arizona providers bring their needs to the attention of HIT and HIE vendors and promotes the development of appropriate solutions to address the needs.

09 - **Statewide Vision and Framework for HIE**

Develops the process and provides the content for Arizona's ongoing vision for health information exchange.

State Level HIT/HIE Business Infrastructure

10 - **HIT/HIE Program Information and Collaboration Office**

Establishes an office and formalizes a program to gather and disseminate information on HIT/HIE related tools and activities.

11 - **Statewide HIE Rollout, Onboarding, and Use**

Develops and implements a plan to expand the statewide HIE Rollout, Onboarding, and Use of its services

12 - **HIT/HIE Assistance to Providers**

Continues, and develops and implements new, programs to assist health care providers adopt and expand the use of HIT/HIE.

Privacy & Security

13 - **Patient Consent Approach**

Creates a common approach that can be used statewide for complying with patient consent requirements. Ensures alignment with state and federal regulations relating to consent for securely sharing physical and behavioral health information.

Technology

14 - **Statewide HIE Services and Technical Architecture Description**

Creates and maintains a resource that describes the services provided by the statewide HIE (functional description), and the statewide HIE technical architecture (technical description)

15 - **HIE Consent Management Engine**

Develops a technical infrastructure to support the common statewide patient consent approach and processes identified in the initiative "Patient Consent Approach." Initiative 13

16 - **Statewide MPI/RLS Expansion**

Explores opportunities to leverage the statewide HIE master patient index (MPI) / record locator service (RLS) technical framework.

17 - **Tools to Support Public Health Reporting**

Develops a strategic approach that uses HIT/HIE tools and resources, including the statewide HIE, to streamline the sending and receiving of data between ADHS and providers.

18 - **Tools and Support for Health Care Transformation: Care Coordination, Analytics, and Emerging Technologies**

Develops a resource to gather and provide information on tools that support health care transformation, including the alignment with new payment models. As needed, develops community-wide strategies for tool implementation.

19 – Integrated Physical and Behavioral Health Information Exchange

Creates and implements a strategy for the integrated sharing of information between behavioral health and physical health care providers.

AzHeC and Meaningful Use

Arizona Health-e Connection is leading the public health reporting aspects of Meaningful Use with our Arizona Department of Health Services. They have engaged the Mirth HIE Platform vendor to be able to deploy a public health meaningful use gateway in 2017 and are piloting the submission of immunizations electronically. Discussion is underway with ADHS to determine if they would need to establish specialized registries in addition to the core Public Health registries addressed in CMS Meaningful Use guidance.

AHCCCS contracts with AzHeC to perform MU Education for all MU objectives including e-prescribing.

Mercy Care Plan (MCO), Mercy Maricopa Integrated Care Plan (MMIC-RHBA) and AzHeC were awarded a CMS Transformation of Clinical Practice Grant (TCPI) that has enrolled 2,500 clinicians in receiving help in improving their care delivery. Through this grant, AzHeC has purchased tools that will enable the clinicians to better understand their members, improve care delivery and reduce costs. One tool is a population health program that can provide predictive analytics and views of a practice's population. The second tool is a data analytics tool which allows for member generated data and reports and provider reporting.

State Innovation Model Planning Grant

AHCCCS received a State Innovation Model Planning Grant (SIM) totaling $2.1 million in May, 2015 to identify new payment and service delivery models to advance broad based health system reform. The purpose of SIM was to spur state-led healthcare innovation that improves system performance, enhances quality of care, and reduces costs for beneficiaries.

Arizona's Innovation Plan centered on three main initiatives that ultimately focused on enhanced coordination for vulnerable populations; specifically those served by the American Indian Health Program, individuals transitioning out of incarceration and into the community, and individuals with physical and behavioral health needs.

For each of the vulnerable populations identified, AHCCCS and its stakeholders identified statewide goals, action steps to achieve the goals and an approach to test whether the model designed has a positive impact in closing the identified gaps in the delivery system. A key theme that emerged was the need to expand the Health Information Technology and enrollment in the Arizona Health Information Exchange (The Network) in order to improve the delivery system statewide, and in particular, support the implementation of care coordination models for vulnerable populations.

Through the SIM Model Design, Arizona sharpened its focus on how the State's HIT policies and infrastructure must be developed to support new delivery system and payment models. The barriers and solutions needed to improve the coordination and delivery of care includes:

1. Expansion of exchange of clinical information on a real time basis, and
2. The provision of data and analytical capability to support providers, payers and other relevant organizations.

Statewide Health Integration Plan (SHIP)

Arizona Health-e Connection was tasked by the State of Arizona to produce an integrated Physical and Behavioral Health Plan for HIE. The Network created a statewide plan to integrate physical and behavioral health providers to information exchange under one infrastructure. The goal is to improve quality and outcomes for Arizona patients who receive physical and behavioral health care. The state level HIE model needs to support providers in developing integrated service delivery models and must contain these essential elements:

- A single HIE infrastructure managed by The Network
- One marketing and communication and messaging strategy for the Integrated HIE for all physical and behavioral services; and
- One financial model that encompasses a single fee for physical and behavioral health care stakeholders to sustain the integrated physical and behavioral health network.

The plan calls for the integration of behavioral health information into the statewide HIE. The three RBHAs funded AzHeC to connect the top 100 BH providers to The Network by May 2018. For a list of the BH Community Providers please see Appendix F.6.

Description of Arizona Health-e Connection and The Network

The Network functions as a Network of Networks. It has direct connections with hospitals, health plans, community health centers, providers, etc. It has connections with other provider based networks including Accountable Care organizations, (ACOs) Integrated Delivery Networks (IDNs) clinically integrated networks, other Health Information Exchanges, etc. and connects to the eHealth Exchange in order to access data from our federal partners including CMS, VA, SSA, DOD, out of state HIEs and in the future, Indian Health Services. For a complete list of participants please go to: https://azhec.org/the-network/the-network-participants/. Refer to the Appendix for a current listing of participants by type. A graphic of these collaborations is provided below.

Figure 13: Arizona Community Collaboration for Health Information Exchange

Data Source: Arizona Health-e Connection

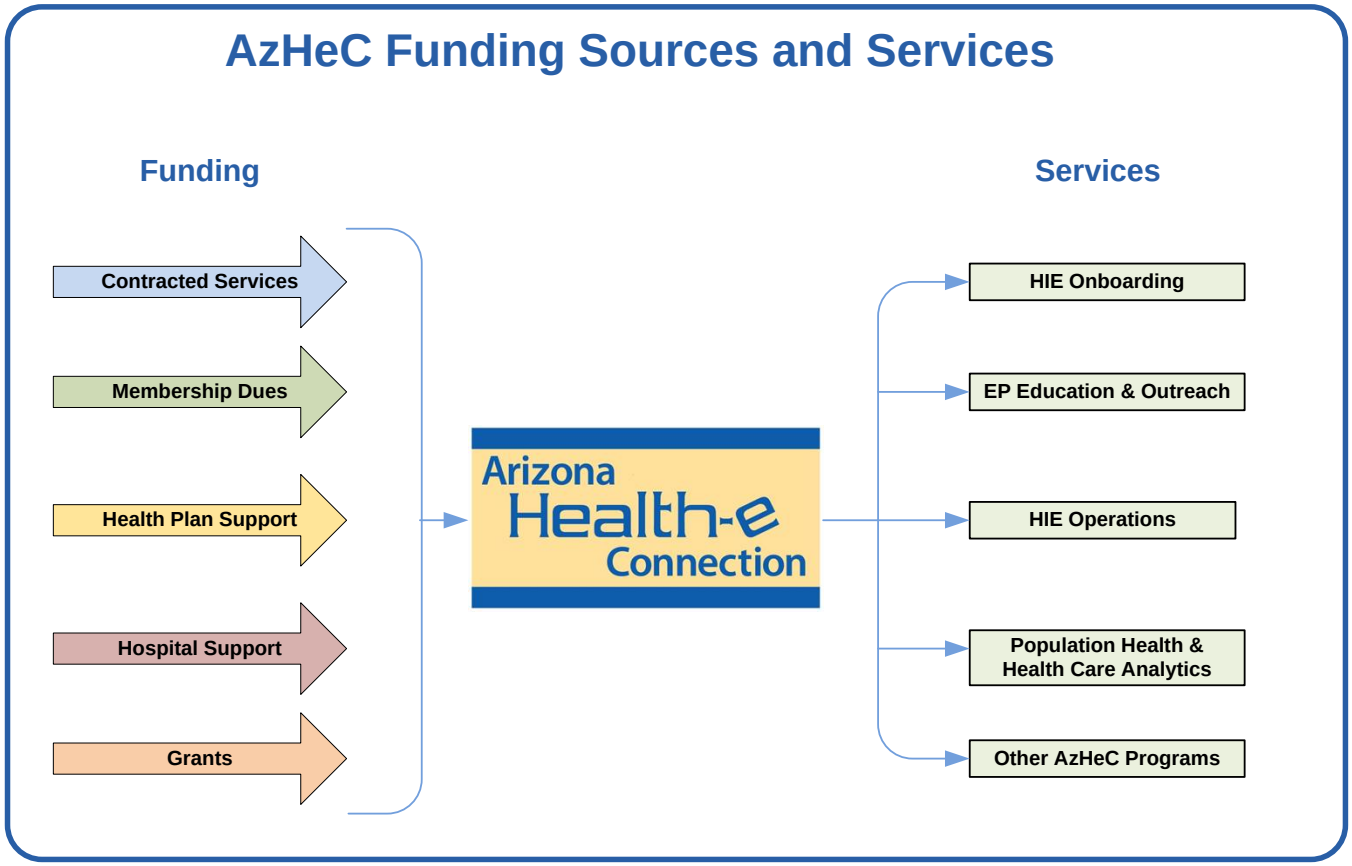
(Section A.7 Continued)

The Network currently supports a standard data set:

- Hospital Admissions Discharges and Transfers (ADT) transactions (problem lists, allergies, procedures, insurance, etc.)
- Medications
- Lab Results
- Transcribed Reports
- Radiology Reports

The figure below is meant to show the mixture of funding sources that are coming into Arizona Health-e Connection and the services or programs they are implementing to support the needs of their membership. AzHeC continues to operate as a one stop shop for Health IT and Health Information Exchange for its stakeholders.

Figure 14: Arizona Health-e Connection Community Funding and Services (2016)



Data Source: AHCCCS HIT October, 2016

A.8 The MMIS Role in the Current HIT/HIE Environment

(SMHP Companion Guide Question A #8)

Roles of MMIS in the SMA Current HIT/HIE Environment

MMIS Integrated to HIT/HIE - *The agency has established a connection with the HIE and is currently viewing data that is available for 200 High Needs/High Cost Members who are enrolled in the Agency's Fee for Service Program/American Indian Health Program. The Division of Health Care Management is developing a use case that could get reviewed by The Network for the purpose of quality of care issues and care coordination and management between itself and the plans.*

The agency has identified some other business operations that could benefit from connectivity to The Network including Child Rehabilitative Services (CRS) eligibility, long term care physical assessments, and meaningful use objectives and CQMs. Plans are being developed for these use-cases.

Summary of Phase 1 AHCCCS MITA 3.0 SS-A Findings – *The Agency completed a MITA State Self-Assessment the Fall of 2016. The following is a summary of Phase 1 AHCCCS MITA 3.0 Findings: AHCCCS is generally operating at a Level 2 and a few areas are operating at a Level 1, with most maturity level scoring impacted by fragmented systems, processes and data. While technology improvement projects such as HEAplus, have provided significant capability improvements in some business areas, AHCCCS continues to have data and processes fragmented across programs and business areas.*

AHCCCS will focus future development on automation and implementing standard data and processes; however many of the MITA Level 3 capabilities still lack national standard definitions. For this reason AHCCCS seeks to standardize and automate to the fullest extent of MITA Level 2 and will explore MITA Level 3 standards as they are developed and adopted by CMS.

MITA Maturity Levels Alignment with the 7 Conditions and Standards – *AHCCCS is in the process of updating its MITA SS-A in 2016 which will include the alignment of the 7 Conditions and Standards, along with the HITECH SS-A. Recent APDs submitted by AHCCCS have all included the 7 Conditions and Standards analysis.*

Summary of Phase II HITECH MITA 3.0 SS-A Findings: - *During Phase II of the SS-A project, the team analyzed the variety of AHCCCS programs, initiatives, and applications ranging from ePIP and AzHeC solutions to the Payment Modernization and Care Coordination Strategies. The findings for Phase II are similar to Phase 1 relative to current and target MITA maturity levels for each business area.*

(Section A.8 Continued)

The diagram in the figure below: **Integrated Medicaid IT Environment (Current Status 2016)** represents a current snapshot of the member and provider interfaces with the agency. It includes the HITECH-related systems and PMMIS, which is primarily a mainframe system with several supporting modules on the network.

Medicaid providers who register and attest for the EHR Incentive Program may be qualified to receive Incentive Payments. They access the Federal and State portals to register and attest.

1. Providers register first at the Federal level with CMS for either the Medicare or Medicaid program using the National Level Repository (NLR). AHCCCS has an electronic relationship with the NLR as part of the administration of the EHR Incentive Program.
2. Next or second, providers register for the Medicaid program with the State. Arizona providers use the state level repository named ePIP, where they also may attest and view their status. The ePIP system validates the providers and their requests and creates the payment requests for the financial system.
3. Providers receive EHR Incentive Payments in their designated bank account electronically by the Arizona Financial Information System (AFIS).

Several entities including providers and payers, along with the agency access the Health Information Exchange named The Network. They view patient records and receive healthcare alerts for their members. They also exchange health care data using HIPAA transactions.

4. They access the AHCCCS On-Line portal to verify Medicaid patient eligibility and enrollment information, to check on claims status, to update their demographics. They may also submit claims for the Fee for Service Program.
5. They submit patient immunization records, and other patient health data to the public health registries. At this time, ADHS does not accept the majority of its information electronically but is interested in developing the interfaces and electronic capacity by working closely with The Network and its participants. At this time most of the hospitals may have some type of electronic relationship with ADHS for one aspect of the MU program, such as lab reporting, however, that electronic reporting is still a combination of manual and electronic processes, which is being looked at to be improved under the MU program.
6. They access the HIE to view their members' healthcare data and receive alerts.
7. They exchange HIPAA transactions using the EDI process. Larger providers use EDI to submit their claims and verify eligibility for their members. Health plans use EDI for the submission of encounters and the agency sends them lots of information through this mechanism.

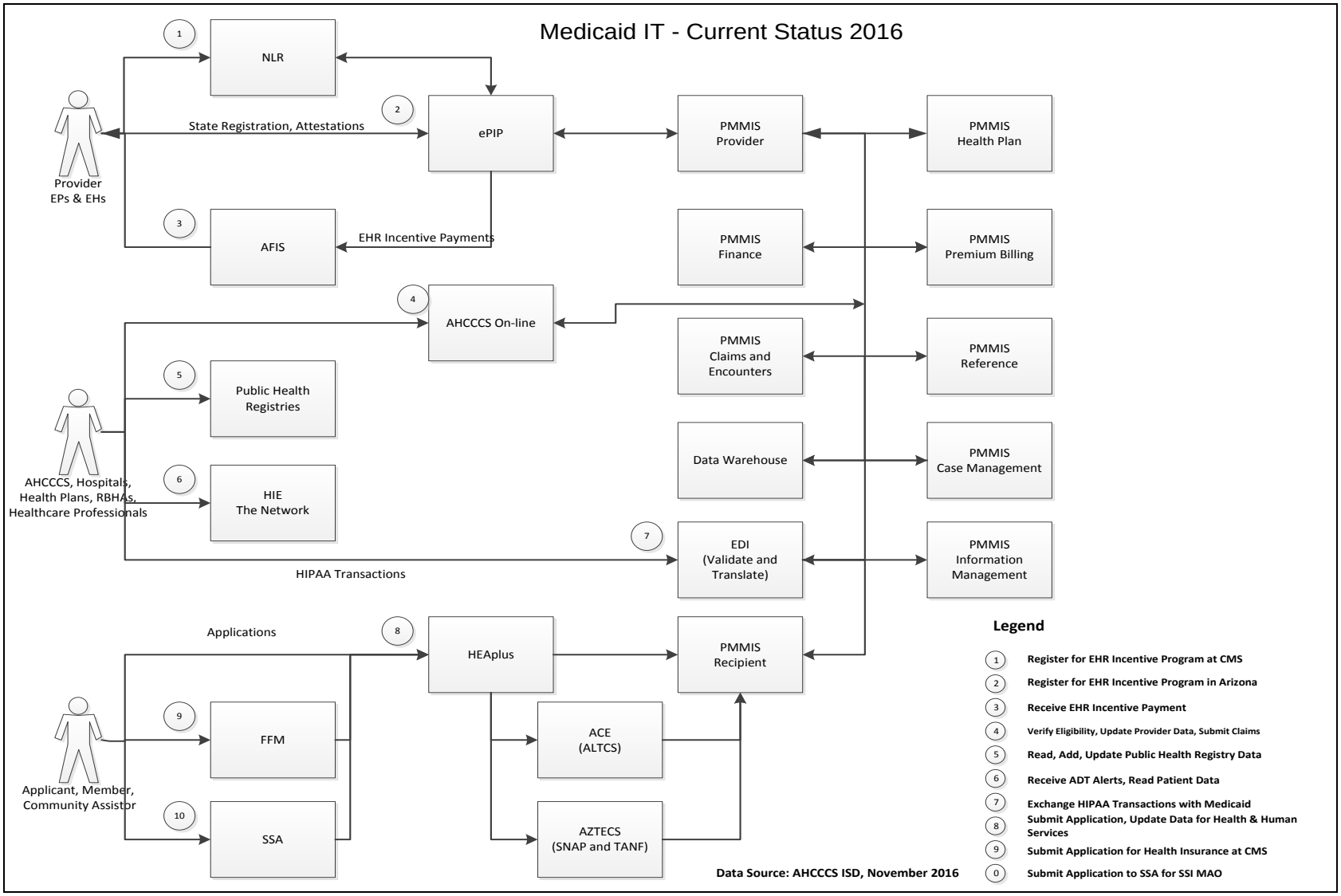
Applicants and members apply for and update healthcare and social services benefits using HEAplus, SSA, or the Federally Facilitated Marketplace FFM).

8. Applicants access Health-e-Arizona Plus to apply for health and human services programs; HEAplus is an online eligibility determination system that collects applicant

data to determine eligibility for Medicaid, CHIP, ALTCS, SNAP, and TANF programs. Eligibility for Medicaid and CHIP is currently determined in HEAplus; for ALTCS, SNAP, and TANF, HEAplus links to ACE and AZTECS to determine eligibility but development is underway to include that capability in HEAplus.

9. Applicants can also apply for Arizona health insurance coverage through the Federal Facilitated Marketplace at HealthCare.gov and, if they appear to be eligible for Medicaid, their eligibility information is sent to Health-e-Arizona Plus for consideration.
   SSA determines Medicaid eligibility when applicants participate or apply to the Social Security Administration (SSA) for supplemental security income (SSI).

Figure 15: Integrated Medicaid IT Environment (Current 2016)



A.9 State Activities Underway to Facilitate HIT/HIE Adoption

(SMHP Companion Guide Question A #9)

State Activities Underway and In Planning for EHR and HIE Adoption

The SMA has contracted for the following services to support the adoption of HIT/HIE activities comprising the operation and administration of the EHR Incentive Program.The SMA has engaged contractors to support or is planning to contract with SMEs for the following:

- The development of the agency's Environmental Scan through survey of EPs
- Recruitment of Medicaid Eligible Professionals to the EHRs Program
- Education and Outreach for Medicaid Eligible Professionals about HIT/HIE
- MU Measure Education
- Audit Program Review and Training
- Administrative Support for program oversight and specialized help like IT, Legal, administrative and or contract management
- Performance of a HITECH MITA State Self Assessment and development of next steps document
- Engagement of SME to assist agency with developing an electronic clinical quality reporting roadmap over the next five years that takes into account the agency's quality measures for the Managed Care Organizations and the MU Program
- Support for Public Health MU Measure Submission using the HIE
- Support for Board of Pharmacy connectivity to The Network for e prescribing of controlled substances for MU Measure of e-prescribing
- HIE Workflow analysis and HIE onboarding of Medicaid Providers
- Data normalization tool for support of more robust data sharing of AHCCCS claims and encounters

The table below is a summry of the activities the SMA is engaged in or planning to be engaged with to facilitate HIT/HIE Adoption.

Table 19: Current and Planned State Activities to Facilitate EHR/HIE Adoption

Current and Planned State Activities to Facilitate EHR/HIE Adoption			
Activity	**Description**	**Contractor**	**IAPD Status**
Annual MD/DO Environmental Scan	Survey of all MDs and DOs conducted at the time of re-licensing regarding adoption of Electronic Health Record technology	Arizona State Univ./ Center for Hlth. Information Research	Included FFY 2016-2017 **To be Included FFY 2017-2018**

Education and Outreach	The SMA has contracted with AzHeC to recruit non-participating Eligible Providers to the EHR Incentive Program and promote continued progress through the stages of Meaningful Use and to improve customer service. AHCCCS is suing approved funding for additional staff at The Network (3 FTEs) to support workflow analysis, HIE onboarding and eRX. Requesting additional funds for e-prescribing campaign.	Arizona Health-e Connection	Included FFY 2016-2017 **To be Included FFY 2017-2018**
Audit Review and Update	The SMA has hired a SME to assist with audit training, education and updating to its Audit Toolkit and processes to ensure CMS compliance. AHCCCS is implementing an expanded scope of work to respond to the HHS_OIG audit and will be updating its audit strategy and procedures based on the findings.	Myers and Stauffer	Included FFY 2016-2017 **To be Included FFY 2017-2018**
Temporary Services – Legal, IT and Customer Service/Administration	Temporary Staff can be accessed if needed to support the agency administration and oversight of the EHR Program and can be done to supplement IT, legal, customer service, etc. to assure timely payment and strong program integrity.	Superior Group/All About People/ABF Professionals /Corporate Job Bank	Included FFY 2016-2017 **To be Included FFY 2017-2018**
MITA Self-Assessment (completed)	The SMA participated in a MITA Self-Assessment this FFY. The EHR Incentive program conducted a dedicated HITECH MITA Self-assessment. Agency roadmap is being developed	Cognosante	Included FFY 2016-2017 **To be included FFY 2017- 2018**
eCQM Compliance	The SMA may hire a subject matter expert to assist with EP reporting compliance with eCQM and Meaningful Use Measures.	To Be Determined	Included FFY 2016-2017 **To be Included FFY 2017-2018**
EH/FQHC/ Physician Group HIE Onboarding and other Medicaid Providers as allowed under SMD #16-003	The agency is Onboarding Eligible Hospitals, FQHCs and Physician Groups to the State Level HIE. Adding non-eligible providers as allowed under SMD 16-003	AZHeC/The Network	Included FFY 2016-2017 **To be Included FFY 2017-2018**

Increased eRX submission of Controlled Substance Scripts	AHCCCS will be seeking funding to support improved compliance with Medicaid provider's submission of routine eRx and controlled substance eRx orders.	Board of Pharmacy/ The Network	**To be Included FFY 2017-2018**
Public Health Reporting for MU Compliance	AHCCCS will be supporting piloting of the Arizona Department of Health Services and the Health Information Exchange to test submission of EP public health reporting data through an HIE Gateway.	ADHS/The Network	**To be Included FFY 2017-2018**
Hold for Purchase of DATA Normalization and Quality Tool for The Network	In order to allow larger repository of claims and encounter data from participants , data must be “normalized” cleaned and standardized in order to facilitate aggregation for population health and data analytics.	TBD	**To be Included FFY 2017-2018**

Data Source: AHCCCS HIT October, 2016

Just as a note- The agency is using NON-HITECH funds to establish connectivity with The Network for the purpose of supporting the American Indian Health (AIHP) Program run by the Division of Fee for Service Management.

Current Non-contracted Services

The activities in the following table were initiated and completed in 2015 in-house, in support of the EHR Incentive Program and did not require external contractual support.

Table 20: Current State Activities to Facilitate HIE/EHR Adoption – Non-Contracted Services

Current Agency Activities to Facilitate HIE/EHR Adoption - Non-Contracted			
Activity	**Description**	**Contractor**	**IAPD Status**
Review of the SMA Environmental Scan - Satisfaction Survey Outcomes	The SMA created and distributed an online survey to assess Eligible Provider satisfaction with the registration and attestation portal and the EHR Incentive Program Team support.	Performed by SMA Staff	Not Applicable

White Space Analysis - Review and Update	The SMA extracted data from the National Level Repository to identify EPs, by Geographic location, that have not participated in the EHR Incentive Program.	Performed by SMA Staff	Not Applicable

Data Source: AHCCCS HIT October, 2016

SMA Role in Facilitating HIE and EHR Adoption

AHCCCS has a multi-pronged strategy with numerous initiatives to facilitate HIE and EHR Adoption. Using the HITECH IAPD enhanced funds; the agency is deploying resources to participants and staff that are a part of the EHR Incentive Program in 3 different ways.

1. Internal Staffing/EHR Program Administration –

Within the agency, AHCCCS has increased the number of fulltime FTEs that work on the program, particularly in our Information Technology area. There are now 3.5 fulltime FTEs who help with resolving technical problems with our electronic provider incentive portal (ePIP) and who do all the programming and security for this project. The agency builds and operates its own EHR Incentive Program portal called ePIP which stands for Electronic Provider Incentive Payment System. Across the agency, other divisions including OOD, DHCM, OALS, DBF, DMS, OIG and DFSM contribute staff time to the administration and oversight of the EHRs Incentive Program. (See Section C.14 for an organizational chart of the staff who oversee the EHR Incentive Program in the Division of Health Care Management and the Office of Inspector General)

Through its staffing, the agency handles all aspects of administering the EHR program including recruiting and registering non-participating providers, providing pre and post payment attestation reviews, handling customer service in coordination with AzHeC for the EHR program participants, performing audits, and managing communication with providers related to the program. AHCCCS Office of Inspector General provides grievance and appeals for the participants, receives reports of fraud and abuse, and performs and oversees post pay audits.

2. Agency HIT Contracts

As detailed in the table above, the agency contracts with several organizations or specialized subject matter experts to support the EHR program. Through contracts with temporary staffing firms or specialized contractors, the agency meets the administrative and oversight requirements of the EHRs program. The agency has used temporary IT staffing to upgrade security and to assist with building ePIP changes to accommodate rule changes or improve security. The agency may hire other additional temporary administrative help to accelerate the processing of provider attestations and payments, if needed.

The agency has had an Interagency Service Agreement (ISA) with the researchers at Arizona State University and the Center for Health Information and Research (CHIR) to perform an annual survey and assessment of physicians EHR Adoption and Use trends. This survey is conducted during the physicians' annual license renewal cycle at the Arizona Board of Medical Examiners and the Osteopathic Board. Findings from this part of the agency's ENVIRONMENTAL SCAN are located in this Section A. The agency also has contracts with Myers Stauffer for auditing SME, Cognosante for the MITA State Self-Assessment and contracts with Arizona Health- e Connection for expansion of Education and Outreach, HIE workflow and E-prescribing, and HIE onboarding.

(Section A.9 Continued)

Describe REC or Other Similar Entities Continuing to Operate

The agency has continued to have a relationship with Arizona Health-e Connection (AzHeC) which ran the ONC funded Regional Extension Center (REC) Program. The agency secured a non-compete contract with AzHeC to continue outreach and education for those EPs that had not yet registered or attested to the Medicaid EHR Incentive Program. AzHeC is targeting high volume Medicaid providers that appear eligible for the Medicaid EHR Incentive Program.

The agency entered into a contract with an Audit Subject Matter Expert (Myers and Stauffer) to enhance its pre and post payment processes and to update it's audit strategy. The contract started in Q2 of 2015 and is expected to run through the life of the program.

3. HIE Onboarding Support for Medicaid EPs that participate in the EHR Program

To accelerate HIE adoption, the agency launched an HIE onboarding program in 2014 with Arizona Health-e Connection which operates "The Network". The HIE onboarding program started with paying for HIE onboarding for Eligible Hospitals and Federally Qualified Health Centers and has since expanded to include other Medicaid providers.

The agency's current HIE onboarding program was created to help lower the costs of adopting health information exchange for Eligible Hospitals, FQHCs, and groups of EPs that have received a Medicaid EHR Payment. **The HIE onboarding program is expanding to provide Onboarding payments to The Network for other Medicaid Providers as long as they enable an Eligible Professional or Hospital to meet a meaningful use objective as provided in SMD #16-003.**

The first payment for milestone #1 is when an EH, FQHC, or physician group signs a participation agreement, the second payment for milestone #2 is when one-way connectivity from or to the eligible participant to AzHeC is complete. The third milestone #3 is when one-way connectivity from AzHeC or to the eligible participant is complete.

Milestone 4 payment will be made to AzHeC once Milestone 1, Milestone 2 and Milestone 3 have been completed and invoiced for a provider. AzHeC then passes a portion of the payment onto the provider to help defray their internal costs of connecting to The Network.

The optional Milestone 5 payment will be made when an Eligible Participant establishes a need for additional connectivity services provided by The Network such as DIRECT accounts, public health connectivity.

HIE Adoption Plans and the Role the SMA Plays

AHCCCS has added a contract requirement to the MCO Acute Care plans requiring them to participate with The Network. It is expected that the Medicaid MCOs will be able to improve their care coordination abilities by getting access to real time clinical data that is available at the Network. As of November 1, 2016, 224 organizations have joined The Network and are in various stages of completing their interfaces.

(Section A.9 Continued)

The current services being offered by the HIE include:

Bi-directional Information Exchange

- Push/pull or query/response functionality

Provider Portal/Payer Portal

- Download and single-sign-on EHR integration capabilities

Alerts & Notifications

- Delivery of ADT Alerts and Clinical Results Notifications n both human and machine readable formats

Direct Secure Email

- Secure email for clinical information exchange; Direct Trust certified and HIPAA compliant

Public Health Reporting is under development with the Arizona Department of Health Services

- The Arizona Department of Health Services is evaluating if it will develop interfaces for the immunization registry, electronic lab reporting, syndromic surveillance or any specialized disease registries or other registries such as a lead registry

eHealth Exchange

- Supports exchange with VA, SSA, DOD, out of state HIEs, and Indian Health Services later this year

The Network also helps providers comply with Arizona law that requires those who participate in a health information organization (HIO), like The Network, to have in place a consent notification and opt out process.

Data Access and Exchange Methods

Data can be exchanged and accessed through the following methods:

- Viewer access – Patient information can be accessed one patient at a time via a web-based viewer commonly referred to as a virtual health record (VHR) viewer.
- Bi-directional exchange – The Network is connected to a certified EHR allowing a Network participating organization to automatically send patient information to The Network, and it allows patient information from the certified EHR to be queried by authorized Network providers and be available directly through the Network.
- Health Plan exchange – The Network transfers relevant patient data to a Health Plan facilitating use of this data by the plan's authorized users for care coordination and care management purposes.

(Section A.9 Continued)

Data Formats

Data can be exchanged with The Network in one of two formats:

- HL7 Version 2.x. – Discrete data that is machine-readable only and not in a human-readable format.
- Continuity of Care Document (CCD) using HL7 Version 3.x. – Data presented as a single integrated document that is both machine-readable and human-readable.

Types of Data Exchanged

Utilizing the HL7 v2 standard transactions, The Network collects and is able to supply the following types of patient data to authorized Network users:

- Participating Hospital and Health System Admission, Discharge, and Transfer (ADT) transactions
- Discharge summaries
- Participating Laboratory Results & reports (Microbiology & Pathology)
- Radiology reports from participating Hospitals
- SIU-Scheduling

The following table illustrates the number of HL7 transactions received by The Network for an average monthly total, and in a rolling 12 month total.

(Section A.9 Continued)

Table 21: Rolling 12 Month Inbound Totals to The Network - September 2016

Description	August Totals	Monthly Average	Rolling 12 Month Totals
HL7 v2 transactions received by The Network:			
ADT	**6,003,248**	**3,736,981**	**44,843,770**
Lab	**2,317,953**	**2,386,666**	**28,639,992**
Radiology	**197,277**	**186,656**	**2,239,869**
Transcription	**806,145**	**789,815**	**9,477,785**

C-CDA CCD transactions received by The Network:			
CCD	**11,315**		**628,178**
Totals	**9,335,938**	**7,100,118**	**85,829,594**
MPI Total Patients	**7,218,236**		
Total Patients with Clinical Data	**6,524,900**		**90%**
Query-Response Transactions			
Alerts and Notifications	**89,002**		**1,062,356**
Portal Access	**21,843**		**85,124**
Total Registered Users	**2,923**		
Total Active Users	**328**		

Data Source: Arizona Health-e Connection, September 13, 2016

Fee Structure for the Network

Arizona Health-e Connection updated its fee structure in 2015 which has resulted in a lot more organizations joining The Network. AzHeC eliminated any fees to community providers who want to join the Network. Health Plans and Hospitals each pay 50% of the ongoing operational fees which are offset by any grants or other funding the Network receives.

After other funding sources are incorporated, hospital and health plans split The Network's operational costs 50-50

- Hospitals pay based on discharges (per discharge rate)
- Health plans pay based on allocated share (agreed upon by plans)

Fees for other stakeholder types are under consideration

The Network is able to keep rates low based on continued availability of AHCCCS HIE Onboarding Subsidy Program funding to subsidize participant rates.

- Many Network Participants are required to be an AzHeC member and pay AzHeC membership dues in addition to The Network fees

There are significant Statewide HIE Benefits to Participants

- One Connection
- New Patient Information
- Timely Information to Coordinate Care
- Medical Histories from Out of State Sources and
- Secure Communication

(Section A.9 Continued)

State Activities Underway for Health Information Exchange

A key principle of The Network has been its commitment to work actively with its participants to accommodate their specific needs regarding connectivity and technical standards. Due to the variability in connectivity, several options have been created in order to help participants successfully connect to The Network. New services and connectivity options have been made possible since The Network adopted a new technology platform in early 2015 and this has been a critical factor in its growth.

The AHCCCS HIE Subsidy Program was developed to support the needs of AHCCCS providers in meeting Meaningful Use requirements related to health information exchange. Those needs continue today, as providers continue to progress through the Meaningful Use stages. Additionally, there are new, evolving drivers for providers related to health information exchange, including: 1) the increasing market pressures for providers to enter into value based purchasing contracts, 2) the national efforts by CMS to promote the transformation of clinical practices to encourage and position these practices to participate in the evolving performance and value based payment programs, and 3) the increasing focus on the integration of behavioral and physical health care delivery.

Since migrating in April 2015 to the new HIE platform (MIRTH) with its extensive new services, The Network has seen a reinvigorated enthusiasm from Providers for participating in the HIE and in the willingness to exchange patient information. This has resulted in a steady growth in participation in The Network.

In order to continue to foster and harness this enthusiasm and growth in participation, The Network recommended the expansion of the AHCCCS HIE 90/10 Subsidy program to include eligible hospitals, FQHCS/RHCS and Look A-likes and all Medicaid MU eligible professionals**.**

In this State Medicaid HIT Plan submission, AHCCCS is requesting permission to onboard any Medicaid provider that assists an eligible hospital or professional to meet an MU requirement. This request is to allow AHCCCS to implement the new guidance found in the SMD Letter #16-003 which expands the scope of state expenditures for providers eligible for the 90 percent matching rate and supports the goals of Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0.

AHCCCS has updated its HIE Subsidy Program to permit AzHeC to bill for up to 4 core milestones per participating organization, plus an optional 5th milestone for those organizations that may require additional services (like establishing a DIRECT account) to pursue a Meaningful Use measure. This program allows each participant to select how it can connect and exchange data within its current technical landscape and to be able to establish a connection to the Public Health Gateway under milestone 5.

The program still incentivizes the creation of long term bi-directional data sharing and inclusion of multiple provider groups, hospitals and FQHCs/RHCs and Look A-Likes and EPs. With this new guidance AHCCCS and The Network anticipates that any other Medicaid provider that assists an eligible EP or EH to meet an MU objective will be wanting to join The Network.

(Section A.9 Continued)

The milestones are as follows:

1. Milestone 1 – Recruitment of Participant through signed Participation Agreement

2. Milestone 2 - Unidirectional Exchange
    a. This milestone can be satisfied with options under #2 or #3 below

3. Milestone 3 – Bi-directional Exchange
    a. This milestone can be accomplished by completing at least one option under both #2 and #3 below

4. Milestone 4 - Participant Incentive Subsidy
    a. This subsidy will only be provided once all three previous milestones (recruitment, unidirectional exchange and bi-directional exchange) are accomplished

5. Optional Milestone 5 – Establishing DIRECT Accounts and/or Public Health Gateway Submissions for MU Measures

The tables below represent an updated fee schedule that AHCCCS would pay to The Network upon completion of the Milestones to Medicaid Participants. AHCCCS would pay these fees once billed by The Network.

Table 22: Proposed 90/10 Subsidy Program Fees

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Milestones & Options	Milestone Fee	FFY 2017	FFY 2018
Total Program Fees:		$4,200,000	$4,200,000
#1 – Recruitment:			
Includes all recruitment activities, fully executed agreements, patient consent guidance, and workflow review and redesign support (5 hospitals & 70 practices)	$15,000	75	75
#2 – Participant Data to The Network - Options:			
A. Interface Development: HL7 v2 Data Feed to The Network - all transactions types (15 practices)	$20,000	15	15
B. Interface Development: HL7 v3 or CCDA Data Feed to The Network - all transactions types(15 practices)	$22,000	15	15
C. Interface Development: HL7 v2 Data Feed to The Network for ADT transactions only Plus: Interface Development: Query-Response (non-eHealth Exchange) to supply the remaining Lab, Rad and Transcription transactions (5 hospitals)	$35,000	5	5
D. Interface Development: HL7 v3 or CCDA Data Feed to The Network for ADT transactions only Plus: Interface Development: Query-Response (non-eHealth Exchange) to supply the remaining Lab, Rad and Transcription transactions	$37,000		
E. Interface Development: HL7 v2 Data Feed to The Network (for ADT, Lab, and Rad transactions) Plus: Interface Development: Inbound to The Network using XDS.b protocol (for all transcribed documents)	$50,000		

(Table 22 Continued)

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Milestones & Options	Milestone Fee	FFY 2017	FFY 2018
F. Interface Development: HL7 v3 or CCDA Data Feed to The Network (for ADT, Lab, and Rad transactions) Plus: Interface Development: Inbound to The Network using XDS.b protocol (for all transcribed documents)	$50,000		
G. Interface Development: Direct Secure Email to The Network with CCDA/CCD encounter summary	$19,500		
H. Interface Development: Vendor hosted cloud-based service sending a CCDA/CCD encounter summary via a single interface (30 practices)	$5,000	29	29
#3 – The Network Data to Participant - Options:			
A. Interface Development: HL7 v2 Data Feed from The Network - all transactions types (10 practices)	$22,000		
B. Interface Development: HL7 v3 or CCDA Data Feed from The Network - all transaction types (10 practices)	$27,000		
C. eHealth Exchange: Query-Response	$25,000		
D. Interface Development: Query-Response non-eHealth Exchange (5 hospitals)	$45,000	5	5
E. Alerts & Notifications includes Direct Secure Email & Provider Portal (70 practices)	$20,000	70	70
F. Interface Development: Direct Secure Email from The Network with CCDA/CCD encounter summary	$13,500		
G. Interface Development: Vendor hosted cloud-based service receiving a CCDA/CCD encounter summary via a single interface (30 practices)	$5,000		

(Table 22 Continued)

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Milestones & Options	Milestone Fee	FFY 2017	FFY 2018
#4 – Participant Incentive Subsidy:			
1. Hospital Incentive Payment	$20,000	5	5
2. FQHC & RHC Incentive Payment	$10,000		
3. Community Provider Incentive Payment (practices of 1 to 10 providers)	$5,000	19	19
4. Community Provider Incentive Payment (practices of 11 to 25 providers)	$5,000	19	19
5. Community Provider Incentive Payment (practices of 26+ providers)	$10,000	21	21
#5 – Optional Meaningful Use Support Services (Fees are per entity; all combinations allowed):			
1. Direct Accounts Only (for transport between providers)	$5,000		
2. Public Health: Immunizations	$15,000		
3. Public Health: Reportable Labs	$30,000		
4. Public Health: Syndromic Surveillance	$23,000		
5. Public Health: Disease Registries (per registry)	$17,000		

Summary of AHCCCS HIE Onboarding Subsidy Program with The Network

- **Onboarding Support**: AzHeC/ The Network will support the following activities of Eligible Participants to establish the bi-directional connection with The Network:
  - Participation Agreement Execution
  - Development and orientation of privacy and security policies and processes to support the patient consent process at Eligible Participant
  - Building, testing and implementation of appropriate technical interfaces

(Section A.9 Continued)

- **Program Eligibility**: Eligibility to participate in the Medicaid subsidy program is based on several factors. Each eligible type of provider listed below must have received a Medicaid EHR Incentive Payment from the State of Arizona and must be:
  - An Arizona Acute Care hospital or
  - An Arizona FQHC, FQHC-look A-Like or Rural Health Clinic or
  - *An Eligible Professional that has received a Medicaid Payment and be a part of a group practice or solo practice and,*
  - ***NEW TO THIS SMHP SUBMISSION is the request to access 90 percent HITECH funds, for activities that promote other non-eligible Medicaid providers use of EHRs and HIE when the State expenditures on these activities helps an Eligible Provider meet an MU objective. (SMD#16-003)***

- All Network Participants must also:
  - Abide by the HIE Onboarding Subsidy Program Requirements which include the signing of The Network's HIE Participation Agreement (including any one time or ongoing financial payments made to The Network to support ongoing operations)
  - Sign the HIE Onboarding Subsidy Program amendment to the participation agreement,
  - Agree to completing bi-directional connectivity with the Network and
  - Agreeing to continue HIE participation for at least three years after initial connectivity is complete.

AHCCCS Agency Connectivity and Use of The Network

The AHCCCS Division of Fee for Service Management (DFSM) established connectivity to The Network to assist with care coordination for its members who are enrolled in the American Indian Health Program or AIHP. The DFSM care managers are receiving Hospital Admissions, Discharges and Transfer alerts (ADT) to initiate coordination of care for their AIHP members. The interface and testing was completed in July, 2016 and care coordinators are becoming more familiar with the HIE. The connectivity was paid for with NON-HITECH Funds.

AHCCCS envisions that it will learn a lot about The Network and how its AIHP program is using the clinical data which would then allow it to create a "Lessons Learned Summary" for its Senior Leadership.

Once the AzHeC Board expands the permitted use definition to move beyond "care coordination" and allow for things like payment and operations, the agency would like to activate other units use and connectivity to The Network.

The Long Term Care Program, operated under the Division of Member Services, is responsible for determining member eligibility for its Long Term Care Program, partially based on a member's physical status. The assessment it uses is called a PASS assessment and partially relies on

medical information on that member in order to qualify for the ALTCS program. One of the sub programs under ALTCS program is the Children's Rehabilitative Services Program, or CRS Program. The Agency must determine if children are eligible to enroll in this program, based on medical diagnosis codes and test results.

The CRS unit has also expressed an interest in getting access to the HIE in order to receive the most current medical records it receives from all of the participating clinics, hospitals, and providers. The Division of Health Management may want access to member ADTS to support their quality of care investigations and support care coordination.

Agency Use of HIE Policy Levers

The agency established a requirement that each Program Contractor had to join The Network in order to fulfill one its contractual requirements. It is expected that each Program Contractor will be accessing real time clinical data that is a part of The Network for the purpose of improving care coordination and using real time clinical data to improve member care. Each program contractor has signed an HIE Participation Agreement and has agreed to work towards bi-directional data exchange.

(Section A.9 Continued)

The agency has also required each Program Contractor to monitor the e-prescribing rates of its providers and to raise those by 15% - 20% by the end of 2016. Below is a summary of the e-prescribing benchmarks for each of the AHCCCS Acute Plans as of February, 2016.

Table 23: E- prescribing and Health Plans

	Baseline January 1, 2014 - May 31, 2014	July 1, 2015 - Sep 30, 2015	Difference Baseline to QE September 30, 2015	Percentage Change
Acute	42.22%	46.17%	3.94%	9.34%
CARE 1ST ARIZONA	40.57%	45.41%	4.84%	11.92%
HEALTH CHOICE AZ	43.34%	42.82%	-0.52%	-1.20%
HEALTH NET ACCESS	34.58%	45.44%	10.85%	31.38%
MARICOPA HEALTH PLAN	39.67%	44.46%	4.80%	12.09%
MERCY CARE PLAN	40.06%	43.70%	3.64%	9.09%

PHOENIX HEALTH PLAN	40.16%	46.96%	6.79%	16.92%
UNITEDHEALTHCARE	43.70%	49.63%	5.93%	13.58%
UNIVERSITY FAMILY CARE	47.28%	51.15%	3.88%	8.20%
DHS BEHAVIORAL HEALTH	28.80%	48.02%	19.22%	66.73%
MERCY MARICOPA INTEGRATED	31.97%	45.32%	13.35%	41.76%
CMDP	46.57%	57.01%	10.44%	22.42%
CRS	41.82%	51.46%	9.64%	23.05%
DDD	44.03%	53.51%	9.48%	21.53%
LTC	23.76%	25.70%	1.94%	8.17%
BRIDGEWAY HLTH SOLUTION-L	20.70%	20.25%	-0.45%	-2.19%
MERCY CARE PLAN - LTC	23.49%	25.05%	1.56%	6.63%
UNITEDHEALTHCARE LTC	25.98%	29.72%	3.74%	14.41%

Data Source: AHCCCS DHCM, February 2016

(Section A.9 Continued)

How are Regional Extension Center Operations assisting Medicaid Eligible Providers Ongoing Role and Provider Targets for Education and Outreach?

AzHeC was awarded the ONC Regional Extension Center Program in April 2010. The REC Program was successful in assisting hospitals and providers to adopt EHR and achieve success in being able to attest to Adopt, Implement, Upgrade and Meaningful Use Stage 1. The REC assisted over 3,000 Providers in Arizona. Since the grant funding has ended, AHCCCS has contracted with AzHeC to provide a small resource for Education and Outreach to unenrolled but eligible Medicaid Professionals.

AzHeC is targeting to enroll an additional 400 – 500 Eligible Professionals into the AHCCCS EHR Incentive Program by the end of Program Year 2016. AzHeC will provide monthly webinars, newsletters, and phone technical assistance to increase the number of eligible but not enrolled

providers. AzHeC is providing comments or feedback to AHCCCS as it talks with providers with ideas and suggestions of ways the agency could improve its customer r service to those EPs that experienced problems and successfully attested and to outreach to those to get them enrolled, before December 2016, if they had not done that yet. This contract started in mid-year 2015 and is continuing.

Please see discussion of White Space analysis done in Environmental Scan (Question A. 1) for additional information by county about eligible professionals.

SMA Provider Support to Use EHRs for Other Purposes

State Innovation Model (SIM) Planning Grant - The agency received a SIM Model Design planning grant which identified gaps or challenges providers have when trying to share or provide real time clinical quality data in a transformational plan that assessed different payment and care delivery models that improve the patient experience (including quality and satisfaction), improve the population health and reduce per capita costs of healthcare in the strategic focus areas below:

1. Enhance coordination and integration between physical health and behavioral health providers for adults and children.
2. Improve justice system transitions through development of HIT/HIE infrastructure and health plan interfaces to coordinate coverage and care with Arizona Department of Corrections (ADOC), county jails and probation systems.
3. Enhance and develop regionally based care coordination models for the American Indian Health Plan (AIHP) members, including data sharing capacity, collaboration with Indian Health Services, 638 Tribally operated, and non-tribal providers to support provider infrastructure development and reduced delivery system fragmentation.

One of the deliverables of the SIM transformation plan was a Health IT plan that will support communications and real time data exchange among the EPs that make up the care network for each of the 3 target populations. Arizona Health-e Connection hosted and coordinated stakeholder engagement activities needed to develop the Health IT components of the SIM grant.

Statewide Behavioral Health Integration Plan (SHIP)

Arizona Health-e Connection was tasked by the State of Arizona to produce an integrated Physical and Behavioral Health Plan for HIE. AzHeC completed the SHIP that lays out a strategy for onboarding organizations that are integrating physical and behavioral health information exchange under one infrastructure. The goal is to improve quality and outcomes for Arizona patients who receive physical and behavioral health care. The Network wants to ensure it can support providers in developing integrated service delivery models. The SHIP has these three advantages:

- A single HIE infrastructure managed by the Network

- One marketing and communication and messaging strategy for the integrated HIE for all physical and behavioral services; and
- One financial model that encompasses a single fee for physical and behavioral health care stakeholders to sustain the integrated physical and behavioral health network

AzHeC delivered the SHIP to the state this summer. The plan included a list of the top 100 behavioral health organizations that will be targeted to connect to The Network by May 2018 and the list is included in Appendix F.6. Funding for this onboarding project is from the Behavioral Health Plans and is Non -HITECH Funds.

A.10 SMA's Relationship to the State HIT Coordinator

(SMHP Companion Guide Question A #10)

The State HIT Coordinator

The HIT Coordinator who oversaw the ONC HIE Cooperative Agreement Program for the State of Arizona also serves as the Medicaid HIT Coordinator. The State HIT Coordinator sits in the Medicaid agency and reports to the Medicaid Director. See page 7 for an organizational chart. The REC program was never a part of the SMA, and has always resided outside of state government. AHCCCS oversees all aspects of the Medicaid EHR Incentive Program.

A.11 SMA Activities to Influence EHR Incentive Program and Use of HIT/HIE and Data

(SMHP Companion Guide Question A #11)

The direction of the EHR Program over the next five years will be to keep as many providers who attested to AIU, MU1 and MU2, and MU3 participating in the EHR Incentive Program. Through collaboration with the HIE, the agency is focused on getting as many providers onboarded and sharing data using the statewide infrastructure that is at The Network.

Description of other activities underway that will influence the EHR Program

Completion of MITA State Self-Assessment

The Agency just completed its MITA SS-A. AHCCCS is generally operating at an As Is MITA Maturity Level of 1 and 2 across the MITA business areas. The assessment found that for most of its operations, the capability scores are operating at a Level 2, and a few areas are operating at Level 1 with most maturity level scoring impacted by fragmented systems, processes and data. While technology improvement projects such as HEAplus has provided significant capability improvements in some business areas, AHCCCS continues to have data and processes fragmented across programs and business areas.

AHCCCS will focus future development on automation and implementing standard data and processes; however many of the MITA Level 3 capabilities still lack national standard definitions. For this reason AHCCCS seeks to standardize and automate to the fullest extent of MITA Level 2 and will explore MITA Level 3 standards as they are developed and adopted by CMS.

Based on the HITECH portion of the SS-A the SMA will continue to participate with The Network to develop a portion of its longer term data sharing and clinical quality improvement strategies.

Statewide HIE Integration Plan (SHIP) for Behavioral Health Providers & Hospitals

In 2016, the Regional Behavioral Health Plans contracted with Arizona Health-e Connection to onboard to The Network their priority BH providers. Working with The Network, the RBHAs identified their high priority behavioral health providers by region of the state. The SHIP calls for integration of behavioral health information into the The Network and is expected to connect the top100 BH providers by May, 2018.

The prioritization was generally based on the following priorities:

1. Crisis Network data suppliers and data users
2. Priority Providers as identified by each RBHAS
3. Priority Providers shared between multiple RBHAs and
4. Any remaining Priority Provider

For a complete list of Behavioral Health Community Providers that are targeted for onboarding please see Appendix 6.

Linking Hospital Achievement of MU to Value Based Payment

On December 3, 2015 AHCCCS released a proposed rule that would allow AHCCCS to pay a 0.5% increase to registered Hospitals which met the Agency established value based performance metrics requirements of having achieved a Medicare MU Stage 2 payment and be submitting data to The Network including admission, discharge, and transfer information inclusive of emergency department services. At this time it is expected that 42 hospitals will be receiving the VBP payments due to their successful HIE onboarding by June 1, 2016.

Importance of Data Sharing and Connectivity for Justice Involved Individuals

AHCCCS works with its local justice system providers including the State Department of Corrections and most county jails to suspend Medicaid member enrollment while members are incarcerated. The SMA suspends enrollment when a member goes into corrections and now it is working to ensure that treatments or clinical services that are delivered during incarceration can be recorded and made a part of a patient's record to ensure continuity of care when that member leaves correctional health and goes into the community. AHCCCS has plans to work with this population more to ensure that care delivered while incarcerated is available to primary care providers upon release and that health plan enrollment is completed prior to release.

Establishing Agency Connectivity to The Network

In September 2016, the AHCCS American Indian Health Program (AIHP) established connectivity with The Network to support care coordination for a small number of its AIHP members. AIHP is receiving ADT alerts from The Network when one of its High Needs/High Costs members is

hospitalized and the care coordinators are able to view labs and images from any of the Networks' participants. The AIHP is for members enrolled in the American Indian Health Plan which is operated by the AHCCCS Division of Fee for Service Management.

A.12 State Laws or Regulations Impacting the EHR Incentive Program

(SMHP Companion Guide Question A #12)

Changes to State Laws/Regulations and Their Impact on the EHR Incentive Program; Expand focus to include broader HIT/HIE activities

In 2011 and 2012, AzHeC supported legislation that was intended to update medical records laws and remove barriers to HIE. The legislation included the following changes:

- Permitted healthcare providers and clinical laboratories to disclose information to HIOs, if they have HIPAA "business associate agreements" in place that requires HIOs to protect the confidentiality of health information. Being a HIPAA business associate also subjects an HIO to HIPAA enforcement by HHS and the Arizona Attorney General's Office.
- Permitted HIOs to re-disclose health information in a manner consistent with the underlying medical records confidentiality statutes. This ability to re-disclose health information to authorized individuals is essential to the HIE process.
- Removed the requirements for "written" records or documentation.
- Allowed e-prescription for controlled substances.

In 2014, the Health *IT Roadmap 2.0* stakeholder engagement process was run by Arizona Health-e Connection, stakeholders. It did not request any changes in state laws or regulations that might affect the implementation of the EHR Incentive Program. No laws or regulations were recommended to be changed in 2014.

In the last two legislative sessions there has been activity that has addressed substance abuse by requiring AHCCCS contractors to intervene if someone receives more than 10 prescriptions in a 3 month period (SB 1032) and requires the Board of Pharmacy to provide access to the Controlled Substance Prescription Monitoring Program (CSPMP) to prescribers licensed under the Controlled Substances Act. (SB 1370) In 2016, Senate Bill 1283 passed which requires all prescribers to access the CSPMP before prescribing opioids.

AHCCCS is working with the Board of Pharmacy to identify it's interest in joining Arizona Health-e Connection and having its data be a part of The Network and/or through participation as a specialized registry as part of the MU Program.

Broader HIT/HIE Activity related to Progress Accessing Super Protective Information using HIE

Currently the HIE is receiving 42 CFR Part 2 protected information from 2 behavioral health providers. They are currently working with 6 other providers to start receiving their information as well.Once the volume is sufficient, and the necessary consent management process is in place, The Network plans to begin the sharing of 42 CFR Part 2 information in the HIE (as approved by necessary consent). This is targeted to be done before the end of 2016 or early 2017.

SAMHSA Grant

Arizona Health-e Connection received a SAMHSA grant in 2016 to address the sharing of opioid treatment data through health information exchanges in cases of care discontinuity. In the use case, AzHeC had to ensure that the 42 CFR Part 2 Regulations privacy protections were maintained. AzHeC delivered this to SAMHSA in October, 2016.

The primary objective of the grant was to facilitate a clients' ability to share medication dosing information in cases of care disruption that is compliant with the 42 CFR Part 2 regulations pertaining to access to substance abuse information. The project included multiple Arizona Opioid Treatment Provider (OTP) sites, each with their own electronic health record (EHR) system, that provided the OTP treatment information to the HIE which allowed clients to share their dosing information with other providers when needed and in compliance with 42 CFR Part 2 requirements.

SAMHSA Grant Participants

The study included the following partners/systems:

- Arizona Health-e Connection which operates ***The Network***, Arizona's statewide HIE
- Maricopa County Correctional Health Services – CHS provides integrated health and restoration services to patients in the jail system in Maricopa County within Arizona. Two CHS sites participated in the study: 4th Avenue Jail and Estrella Jail. Both sites use ***TechCare*** as their EHR.
- Southwest Behavioral & Health Services – SB&H provides behavioral health services throughout the state of Arizona. The EHR utilized by SB&H is ***HIMS.***
- Valle del Sol – VDS provides primary healthcare and mental health services in the metro Phoenix area. The EHR used by VDS is ***NextGen.***
- Zen Healthcare IT – The Zen team has many years of real-life, hands-on experience with Mirth and other interoperability tools, interface design and management, third-party integrations, and health information exchange technical projects. Zen was utilized to provide the technical support for ***Mirth***, the system behind The Network (Arizona's HIE).
- Consent Management – The electronic consent management software that was utilized was ***Consent2Share***.

SAMHSA Grant Objectives

The objective of the SCP was to leverage an existing HIE to support the exchange of opioid dosing information between OTPs in a manner that adheres to federal, state, and local privacy requirements. The grant needed to demonstrate that one of the OTP sites can serve as a dosing site when the other site(s) are unavailable through the use of the HIE's online secure portal in a test environment. The pilot needed to demonstrate how an electronic consent process can

manage the sharing of patient health information based on client selected privacy preferences, by the HIE obtaining the patient consent preferences from Consent2Share (C2S) and delivering the appropriate patient information through a secure provider portal in a test environment.

Findings about Sharing Super Sensitive Information

The objective and goals of the SCP were met as it was successfully demonstrated that opioid dosing information could be shared amongst the participating OTP sites utilizing the HIE and based on the patient consent preferences captured electronically. The proof-of-concept was conducted in a controlled test environment. Based on lessons learned, the following outlines items that must be considered to move this process in to a production (aka "live") environment.

1) **EHR Record Information** – Multiple challenges were encountered in obtaining usable record information from the EHR systems to be consumed by the HIE. To move to production the following will need to be managed:
   a) EHR vendor availability – scheduling and prioritization needs to be aligned
   b) Consistency of information – Vendors will need to produce continuity of care document (CCD) records that are consistent in format and content. The information should be standard, coded and predictable.

2) **Treatment Information Identification** – To move to production, it will be important for the OTP clinics to ensure they are capturing all treatment information in their EHRs and coding the treatments and medications correctly.

3) **Value Sets** – the value sets in Consent2Share need to be expanded to include Medi-Span drug coding data and other medical vocabularies and terminologies which are not already included in the Consent2Share Value Sets. This effort is expected to require 15 to 18 months working with substance abuse treatment providers in Arizona.

4) **Natural Language Processing (NLP)** – To ensure all references to protected information are identified and managed correctly, the process cannot rely simply on coded information. It was identified that there are instances of non-coded references to opioid treatment in written documents (notes) within the CCDs. To identify this information, NLP should be acquired and utilized to identify these references and allow for the proper consent handling.

5) **Registration** – For the purpose of the proof-of-concept, patients were manually registered in Consent2Share. In this controlled study this did not cause any issues, however, to move this effort to the production environment this process would most likely prove to be inefficient for the provider sites. During the course of the intake process at each OTP site the patient is registered in the OTP's EHR system. The registration record is then sent to the HIE. For the OTP site to also register the patient in Consent2Share would necessitate duplicate work for the OTP staff. Rather, a process needs to be enabled that allows the registration information received by the HIE to be passed to Consent2Share. In order to accomplish this, a process needs to be developed to identify which registrations received by the HIE need to also be sent to Consent2Share (as not all patients registered in the OTP's EHR may be receiving OTP treatment).

(Section A.12 Continued)

6) **Patient Identification** – Consent2Share needs to be enabled to accept the electronic identification (EID) from the HIE to improve and ensure patient identification matches between Consent2Share and the HIE.

7) **Patient Access to C2S** – During multiple points in the proof-of-concept concerns regarding patient internet access was expressed. While this was controlled in the study, consideration (and potential workarounds) will need to be addressed regarding lack of patient internet access. This can occur both at the OTP sites (such as limited computer terminals) and outside the clinics (lack of patient accessibility to internet). At all points in this process the challenges of internet accessibility need to be taken in to consideration. Below includes some specific areas of concern.

a) **Email** – The Consent2Share process involves emailing the sign on and verification information directly to the patients. This poses challenges that need to be addressed.
   i) Email Accounts – The participating OTP sites each expressed that much of their patient population does not have email accounts. An alternate methodology of providing the sign on and verification information may need to be identified.

   ii) Email accessibility – Circumstances may not permit or allow for the patient to access their email account. While this was a specific constraint that was identified for incarcerated individuals, there may be other situations where this may occur. Another methodology of providing the sign on and verification information may need to be identified.

b) **Computer/Internet Access** – The participating OTP sites reported that in many cases the population that they treat does not have access to a computer. A work around for this is to make computers available in the OTP sites; however, this then puts challenges on the clinics themselves.

c) **Computer Usage** – It cannot be assumed that the patients involved in the process have the knowledge necessary to use a computer and be able to complete the necessary navigation steps. To move to production, the process will need to account for the assistance that will be necessary to facilitate patient use of Consent2Share. This burden will most likely fall on to the OTP sites themselves which will likely affect staffing requirements and costs.

d) **Authorized Representative/Guardianship –** Whether due to diminished capacity, age (minor), or other reason, there are many instances where OTP patients have an authorized representative or guardian. Currently Consent2Share does not have a methodology to allow for these representatives to establish consent on behalf of the patient. To move to production this will need to be accounted for.

e) **Accessible Comprehension** – A review of all patient-facing information will need to be conducted in order to confirm the information is written in a way that allows it to be easily understood by the average person seeking OTP treatment. This includes any help hints or descriptions in Consent2Share and any literature that is provided to the patients. It is advised that this information be written at the 6.5 grade level or below.

f) **Written Consent** – The process must take in consideration that there may be instances where a patient cannot access Consent2Share to provide an electronic consent and that a written (paper) consent would be signed. A method needs to be developed that would allow the OTP clinic to provide a copy of the signed consent to Consent2Share and/or the HIE which would thereby allow the provider to view the needed OTP data in the HIE Portal.

A.13 HIT/HIE Activities Crossing State Borders

(SMHP Companion Guide Question A #13)

HIT/HIE Activities Crossing State Borders

Due to Arizona's geography, most of the health services are delivered within the borders of Arizona. However, there are instances where accessing care out of state is the standard as the Arizona residents are physically closer to a more robust services delivery system in a neighboring state. For example, most people living in the far North West corner of Arizona get specialized hospital care in Las Vegas, Nevada. Also, AHCCCS has a requirement that the health plans have Primary Care, Dental and Pharmacy contracts with providers in Kanab, Utah because it is the closest place for people who live north of the Grand Canyon. Aside from these geographic imperatives, AHCCCS also contracts with some out-of-state hospitals for the provision of covered transplant services that are not available in Arizona.

At this time there are two other state Health Information Exchanges that are participating with The Network. The two HIEs are from Colorado and Utah and are sharing their hospital alerts (ADTs) with The Network in the event an Arizona resident comes in for care while out of state, and The Network is sharing hospital ADTs in the event a Colorado or Utah resident comes into any of the participating Arizona hospitals as an admit with a discharge or transfer. The two participating HIEs that cross state borders, are with the Quality Health Network of Western Colorado and the Utah Health Information Network.

Significant State line Crossings by Medicaid Beneficiaries

The most important care coordination from other states is related to our Medicaid enrollees that are a part of the Indian Health Services. These members travel frequently between New Mexico if they are Navajo and across the other parts of the state. From a care coordination perspective, AHCCCS recognizes that there could be great value in being able to send and receive health records from IHS and the VA as two examples of federal partners.

AHCCCS has let The Network take the lead in getting eHealth Exchange certified in order for the providers to be able to share more successfully with other providers from other states, including federal partners like Indian Health Services, the VA and the Social Security Administration for Social Security Disability payment processing. The HIE has completed the certification for Healtheway with its testing with its HIE technology partner Mirth.

It is our understanding that at this time IHS has preferred to focus on establishing connectivity between themselves and other federal agencies vs state health information exchanges.

A.14 Current Interoperability of State Immunization/Public Health

(SMHP Companion Guide Question A #14)

The Current Interoperability Status of the State Immunization Registry

ADHS is a separate state Agency from the State Medicaid Agency. The Director of ADHS reports to the Governor and for the EHR Incentive Program, Medicaid is totally dependent on making ADHS successful in establishing the functionality needed for EPs and EHs to meet Meaningful Use. The Arizona Department of Health Services link is: http://azdhs.gov/index.htm. ADHS has already established web pages to support providers in meeting Stage 1 of Meaningful Use, located at: http://www.azdhs.gov/meaningful-use.

Immunizations

The Arizona Department of Health Services operates the Arizona State Immunization Information System (ASIIS) or Immunization Registry for the State of Arizona. Under state statute (ARS 36-135 and 32-1974), health care providers are required to report all immunizations administered to individuals 18 years and younger and pharmacists are required to report all immunizations administered into ASIIS.

Pediatric practices most commonly utilize ASIIS, but other practice types report into the system as well including family practice and general physician practices, obstetrician offices, pharmacies, public health departments, community health clinics, IHS facilities, hospitals, military facilities, fire departments, and urgent care centers.

Current Immunization Environment

ASIIS is the statewide immunization registry for documenting immunization administration. ASIIS is accepting HL7 2.5.1 Immunization messages from any organization that is administering vaccinations to children or adults. Immunizations must be reported for patients aged 18 and under.

The Arizona Department of Health Services is currently accepting electronic immunization submissions to the Arizona State Immunization Information System (ASIIS) for Meaningful Use from all providers who administer adult or childhood vaccines. As of January 1, 2017 ASIIS will be ready for Meaningful Use Stage 3, including bidirectional capabilities allowing queries from EHRs.

As of October, 2016 ADHS is continuing its strategic planning efforts to identify opportunities where the HIE can facilitate electronic reporting. There is a pilot underway between The Network and ADHS that will determine the ability of ADHS to consume immunization data from The Network and to share immunization history back to The Network. The pilot is currently working to see if credentials can be exchanged and how best to exchange messages. This pilot is expected to wrap up in February 2017, and to be fully implemented at The Network Public Health Gateway no later than June, 2017.

Funds will be requested in the next HITECH IAPD to facilitate the development and design and implantation of the Immunization Public Health Reporting Gateway.

Syndromic Surveillance-

Syndromic surveillance is a public health measure available for eligible hospitals (EH) and Critical Access Hospitals (CAH) through the Arizona Department of Health Services. There are no plans to accept syndromic surveillance submissions from eligible professionals or eligible clinicians.

Arizona's Syndromic Surveillance program consists of receiving inpatient and emergency department data in a timely manner so that public health can use pre-diagnostic clinical data to understand what is happening in the community. Arizona uses the national BioSense Platform to receive data and conduct Syndromic Surveillance activities. Syndromic Surveillance data is used to support event detection, increase situational awareness, and focus public health actions. Specifically, Arizona has used the data to monitor health during large public events, understand the severity of influenza and look for patients with emerging diseases such as dengue, chikungunya and Zika. ADHS will continue to onboard hospitals and work with public health users to incorporate syndromic surveillance where the data can be useful.

ADHS is expecting to establish an electronic reporting option for Hospitals by testing with The Network in January 2018 with implementation by June, 2018.

Electronic Labs

Electronic Laboratory Reporting (ELR) is the electronic transmission of laboratory reports which identify reportable conditions from laboratories to public health. ADHS has implemented an Electronic Laboratory Reporting (ELR) system to receive reportable disease results from EH/CAH laboratories and reference laboratories and place them into the epidemiology program surveillance databases, including the Medical Electronic Disease Surveillance Intelligence System (MEDSIS).

The ELR system receives standardized HL7 messages containing results from reference laboratories and hospitals. These reportable lab results are parsed to the appropriate state disease surveillance program based on LOINC and SNOMED codes. ADHS continues to onboard hospitals and commercial labs, thereby improving timeliness and accuracy of lab reporting in Arizona. ADHS plans to start testing with The Network for Electronic Lab Reporting beginning by July, 2017 with implementation by December, 2017.

Cancer Registry

At this time there are no registries offered by ADHS that are 'specialized registries' or 'public health registries', other than the Cancer Registry, which is currently accepting registrations from EPs that diagnose or directly treat 100 or more cancer cases in a year.

Other Specialized Registries

The Arizona Board of Pharmacy is responsible for managing the Controlled Substance Prescription Drug Monitoring Program (CSPMP). Due to recent legislative changes, prescribers are required to access the CSPMP before prescribing opioids. The Pharmacy board wants to understand more about the AHCCCS MU Program definitions of becoming a specialized registry and is having discussions with the Network to better understand its architecture and functionality to ensure that whatever gets built will benefit providers and be easy for them to use.

A.15 HIT Related Grant Awards to the State Update Request

(SMHP Companion Guide Question A #15)

Grants in Progress in the Agency

TEFT – Testing Experience and Functional Tools Grant-was awarded to AHCCCS in April of 2014. The purpose of the grant is to further adult quality measurement activities under Section 2701 of the ACA (PPACA). The CMS strategy for implementing the Section is to support the SMA in collecting and reporting on the Adult Core Measures. This tool is primarily intended to test the collection of adult quality measures for use in Medicaid community based long term services and support (CB- LTSS). Arizona has elected to participate in 2 of the 4 components of the TEFT grant which include:

1. Field Test a beneficiary survey,
2. Field Test a modified set of continuity assessment record and evaluation of functional assessment measures

At this time the grant is being managed by the Quality Improvement Unit in the Division of Health Care Management. The HIT Coordinator and HIT Project Manager are a part of the grant steering committee. HIT continues to be a focus of the grant as plans are being considered for long-term sustainability of the grant components being tested.

Grants That Have Closed

State Innovation Model (SIM) Planning Grant - The agency received a SIM Model Design planning grant which identified gaps or challenges providers have when trying to share or provide real time clinical quality data. The grant was meant to be a transformational plan that assessed different payment and care delivery models that improve the patient experience (including quality and satisfaction), improve the population health and reduce per capita costs of healthcare in the strategic focus areas below:

1. Enhance coordination and integration between Physical Health and Behavioral Health Providers for adults and children.
2. Improve justice system transitions through development of HIT/HIE infrastructure and health plan interfaces to coordinate coverage and care with Arizona Department of Corrections (ADOC), county jails and probation systems.
3. Enhance and develop regionally based care coordination models for the American Indian Health Plan (AIHP) members, including data sharing capacity, collaboration with Indian Health Services, 638 Tribally operated, and non-tribal providers to support provider infrastructure development and reduced delivery system fragmentation.

One of the deliverables of the SIM transformation plan was a Health IT plan that identifies at a high level how the agency could support communications and real time data exchange among the EPs that make up the care network for each of the 3 target populations. Arizona Health-e Connection hosted and coordinated stakeholder engagement activities needed to develop the Health IT components of the SIM grant. The full SIM Health IT Plan is posted out on the agency website at: https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/SIM.html

(Section A.15 Continued)

Medicaid Transformation Grant

AHCCCS was awarded a Medicaid Transformation Grant, on January 25, 2007 to develop AMIE. CMS grant funds were used to support the planning, design, development, testing, implementation, and evaluation of an exchange. The inaugural users had Medication history (PBM claims aggregator), discharge summaries (3 hospital systems) and Laboratory Testing results (Sonora Quest). Over time additional providers were trained and additional data was made available, through the federated exchange that had statewide reach. By the time the grant suspended its operations in January of 2009, there were 100+ users in diverse clinical settings with ten hospitals, 6 PBMs and 1 laboratory. AMIE had over 7.6 million records available with over 3.1 million patients in the AMIE Master Patient Index.

AIMIE eventually merged with the Southern Arizona Health Information Network and created the Health Information Network of Arizona, HINAz. HINAz is now “The Network”.

The grant also enabled the creation of an early version of the REC concept, called the Purchasing and Assistance Collaborative for EHRs (PACeHR). It was created to foster EHR adoption and information sharing by leveraging web-based technologies, economies of scale, aligned metrics and strategic partnering.

The PACeHR program closed in January of 2009, but the organizations’ staff consolidated with the Regional Extension Center and supported the RECs efforts to provide EHR screening and assessment processes, provider on-boarding support, and shared contracting expertise for small to medium sized practice groups.

Arizona also received significant funds under the ONC HIE Cooperative Agreement Program and many activities were supported with AzHeC to promote EHR Adoption and to facilitate HIE.

Section B: The State's " To Be" HIT Landscape

B1. Over the next five years what specific HIT/HIE Goals does the SMA want to Achieve

In order to meet its own strategic goals of improving care and reducing costs, AHCCCS has developed health information technology and health information exchange goals and strategies it is using to reduce fragmentaiton in healthcare delivery to develop an intgreated system of healthcare. AHCCCS's Health IT work is focused in its work of "Leveraging HIT investments to Reduce Care Fragementation and Improve Care Coordination".

The three HIT/HIE Program Goals are:

Goal 1: Oversee and Administer the EHR Incentive Program

a. Ensure Providers Migrate Through the MU Continuum

b. Support ADHS Public Health Onboarding for MU Measures

c. Achieve Program Integrity Plan Goals

Goal 2: Increase Agency Use and Support for HIT/HIE

a. Support Care Coordiantion and Integration Between Physical and Behavorial Health Providers

b. Support AHCCCS Payment Modernization Intaitives and Administrative Efficiency Projects

c. Implement Amercian Indian Medical Home Waiver (AIHP)

d. Improve Justice System Transitions

e. Improve Care for Children with Behavioral Health Needs including Those at Risk and Engaged in the Child Welfare System

f. Continue Aency Participation in Qualified HIE for Governance, Policy Making and IT Service Offerings

Goal 3: Accelerate Statewide HIE Participaiton by All Medicaid by Providers and Plans

a. Expand the HIE onboarding Program for Medicaid Hospitals, FQHCs, RHCs Groups and All Other Medicaid Providers

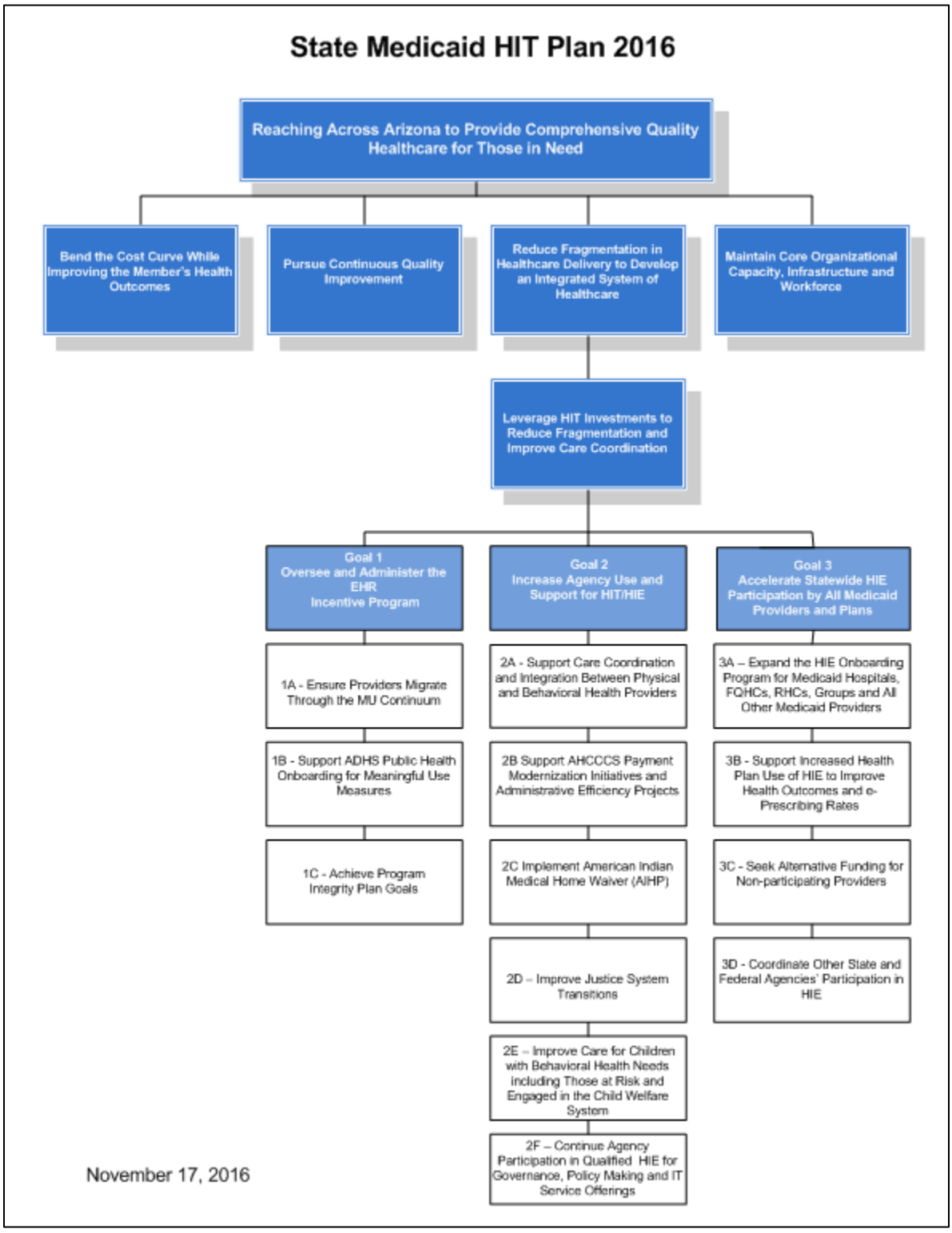
b. Support Increased Health Plan Use of HIE to Improve Health Outcomes and e-Prescribing Rates

c. Seek Alternative Funding for Non-Participating Providers

d. Coordiante other State and Federal Agencies Participation in HIE

See the figure below for a snapshot of the Agency wide HIT Goals and the three HIT/HIE Goals and Strategies supporting them.

Figure 16: HIT/HIE Goals and Strategies



Data Source: AHCCCS HIT November, 2016

(Section B.1 Continued)

Under each goal, the SMA has created strategies it is using to accomplish each goal. The strategies are listed below. A list of benchmarks for each goal are in Section E.

Goal 1: Oversee and Administer the EHR Incentive Program

Strategy 1A - Ensure Providers Migrate Through the MU Continuum
1. Encourage Medicaid providers to adopt, implement, or upgrade to CEHRT 2. Implement and maintain electronic Provider Incentive Payment System (ePIP) 3. Enhance the functionality of e-PIP to be more automated for the administration of the EHR program 4. Implement and maintain communications, materials and tools for providers and members 5. Perform Education and Outreach for eligible but unenrolled providers 6. Partner with program contractors to identify high volume providers that need to register and attest to the MU program. 7. Develop and maintain Policies and Procedures documentation 8. Process provider registrations, attestations and payments 9. Conduct payment audits 10. Report results of the EHR Incentive Program performance to stakeholders 11. Conduct provider surveys to determine the impact of the EHR program 12. Participate in CMS led trainings including Communities of Practice (CoPs), All-States CMS Calls, and HIT-related conferences and events 13. Develop and update State Medicaid HIT Plan (SMHP) and HIT funding documents 14. Use agency MITA State Self-Assessment findings to build HITECH Program planning
Strategy 1B - Support ADHS Public Health Onboarding for Meaningful Use Measures
1. Support onboarding of providers to the HIE in order to access and send information through the electronic Public Health Gateway and ADHS MU Coalition. 2. As appropriate, request HITECH IAPD funds for establishment of ADHS infrastructure for Gateways 3. Collaborate with ADHS to develop a long term plan for using the HIE to enhance public health reporting for Medicaid providers
Strategy 1C - Achieve Program Integrity Plan Goals
1. Ensure Agency has engaged Audit Subject Matter Experts (SMEs) to support the review and implementation of Agency EHR Audit program 2. Update and submit to CMS a new AHCCCS EHR Program Audit Strategy as needed 3. Participate in CMS sponsored Community of Practice for Program Integrity 4. Increase frequency of provider audits and provide audit training as appropriate to providers

Goal 2: Increase Agency Use and Support for HIT/HIE

Strategy 2A- Support Care Coordination and Integration Between Physical and Behavioral Health Providers
1. Monitor the progress of the Statewide HIE Integration Plan (SHIP) that calls for connectivity between the HIE and the top 100 behavioral health providers 2. Recruit any eligible Behavioral Health providers that qualify to the EHR incentive program 3. By July 2017, expand the current HITECH IAPD language to allow for HIE onboarding for non EHR Eligible Medicaid Providers that enable eligible providers can meet MU.
Strategy 2B – Support AHCCCS Payment Modernization Initiatives and Administrative Efficiency Projects
1. Participate in the CMS led Healthcare Payment Learning & Action Network (LAN) to identify opportunities to link alternate payment reform efforts with Health IT/HIE milestones and measures 2. Working across the agency, update the agency's roadmap for data sharing and Clinical Quality reporting that leverages new electronic reporting tools and services.

Strategy 2C –Implement American Indian Medical Home Waiver (AIHP)
1. 1 Support Indian Health Service (IHS)/Tribal 638 primary care site transformation into Patient – Centered Medical Homes (PCMH) 2. Develop care management systems for American Indian populations enrolled in AIHP and receiving services through IHS/Tribal 638 providers and non-IHS/Tribal 638 providers. 3. Develop a data infrastructure that can support data analytics using both clinical data and claims data for providers serving AIHP members. 4. Reduce fragmentation of care among IHS/Tribal 638 and non-IHS/Tribal 638 providers serving AIHP members through regional Care Management Collaboratives that improve outcomes for AIHP members
Strategy 2D –Improve Justice System Transitions
1. Develop an integrated health care setting within county probation offices or Department of Corrections parole offices to address beneficiary health care needs upon release and throughout the term of probation/parole for individuals transitioning out of incarceration. 2. Ensure the county and state correctional entities have signed a Participation Agreement with the HIE. 3. Participate in planning to ensure that Medication History becomes more readily available through the HIE to appropriate providers 4. Over the next 2 – 3 years improve member engagement by increasing transparency and education for justice involved members
Strategy 2E- Improve Care for Children with Behavioral Health Needs including Those at Risk and Engaged in the Child Welfare System
1. Support the integration of behavioral health and primary care services for children in both primary care sites and community behavioral health sites. 2. Improve treatment for the care of children with and at risk for Autism Spectrum Disorder (ASD) 3. Improve treatment for the care of children engaged in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child welfare system, by developing electronic connectivity between providers at the HIE.
Strategy 2 F- Continue Agency Participation in Qualified HIE for Governance, Policy Making and IT Service Offerings
1. Ensure executive participation on the nonprofit Health IT Board of Directors 2. Monitor and support the growth of the state HIE by monitoring all HIE services and delivery of benchmarks to AHCCCS and its stakeholders

Goal 3: Accelerate Statewide HIE Participation by All Medicaid Providers and Plans

Strategy 3A – Expand the HIE Onboarding Program for Medicaid Hospitals, FQHCS, Groups and All Other Medicaid Providers
1. Using federally approved 90/10 HITECH funds, identify eligible providers for the HIE onboarding program to accelerate bidirectional data flows between participating organizations. 2. Claim 90/10 HITECH funds that include HIE onboarding funds for all other ineligible Medicaid providers as long as they support an eligible provider demonstrate MU – (SMD#16-003). 3. Track and monitor HIE onboarding milestones and payments
Strategy 3B- Support Increased Health Plan Use of HIE to Improve Health Outcomes and Clinical Quality Measures
1. Identify opportunities to improve administrative efficiencies with the agency and the plans related to HIE functionality and services. 2. Work with the Health Plan Association to implement an e prescribing campaign for the MCOs by Q1 2017
Strategy 3C- Seek Alternative Funding for Non Participating Providers
1. Participate in researching other federal grants for Health IT related funding opportunities 2. Working with stakeholders, participate in local foundation or community based funding opportunities to maximize number and type of provides that can participate in Health IT/HIE programs.

Strategy 3D- Coordinate Other State and Federal Agencies' Participation in HIE
1. Work with state agencies to coordinate implementation of public health meaningful use measures and other registries that can improve and inform long term population health management 2. Monitor the integration of the Controlled Substance Prescription Drug Monitoring Program (CSPMP) with the HIE to ensure providers can seamlessly access drug information 3. Through the State HIT Coordinator, initiate discussions with other state agencies to educate them about health information exchange and health information technology initiatives 4. Monitor the progress of the Health–e Way Certification/Sequoia Project to ensure the participation of targeted Federal Agencies' in the HIE

11/17/2016

Description of Program Metrics for Goal 1: Oversee and Adminiter the EHR Incentive Program

EHR Registration and Payment Goals for Eligible Professionals and Eligible Hospitals

According to the projections in the table below, by 2020, AHCCCS projects it will have 5,360 EPs registered in the EHR Program with 70 % of them receiving an AIU Payment. 3,075 EPs will receive an MU 1 Payment and 2,176 EPs will receive an MU Stage 2 Payment. It is projected that by CY 2020, 1,500 providers will have received a Stage 3 payment.

Table 24: AHCCCS EHR Goals for Eligible Professionals

AHCCCS Goals for Eligible Professionals EHR Adoption, Meaningful Use Program Metrics FFY 2015-2020						
	CY 2015	*CY 2016 Estimates*	*CY 2017 Estimates*	*CY 2018 Estimates*	*CY 2019 Estimates*	*CY 2020 Estimates*
EP Registered in ePIP	*4,893*	*5,360*	*5,360*	*5,360*	*5,360*	*5,360*
EP Receive AIU payment	*3,113*	*3,574*	*3,760*	*3,760*	*3,760*	*3,760*
Registered EP Received AIU Payment	*63.62%*	*66.68%*	*70.15%*	*70.15%*	*70.15%*	*70.15%*
EP Receive MU Stage 1 Payment	*883*	*1,401*	*1,575*	*2,075*	*2,575*	*3,075*
Successful AIU EP Received MU1 Payment	*28.36%*	*39.20%*	*41.89%*	*55.19%*	*68.48%*	*81.78%*
EP Receive MU Stage 2* Payment	*0*	*42*	*676*	*1,176*	*1,676*	*2,176*
Successful MU Stage 1 EP Received MU Stage 2 Payment	*0.00%*	*3.00%*	*42.92%*	*56.67%*	*65.09%*	*70.76%*
EP Receive MU Stage 3 Payment	*0*	*0*	*0*	*500*	*1,000*	*1,500*
Successful MU Stage 2 EP Received MU Stage 3 Payment	-	*0.00%*	*0.00%*	*42.52%*	*59.67%*	*68.93%*

Data Source: AHCCCS EHR Team November, 2016

Table 25: AHCCCS Program Registration and Payments to Hospitals

AHCCCS Goals for Eligible Hospitals EHR Adoption, Meaningful Use Program Metrics FFY 2015-2020						
	FFY 2015	*FFY 2016*	*FFY 2017 Estimates*	*FFY 2018 Estimates*	*FFY 2019 Estimates*	*FFY 2020 Estimates*
EH Registered in ePIP	*75*	*76*	*76*	*76*	*76*	*76*
EH Receive AIU payment	*72*	*72*	*74*	*74*	*74*	*74*
Registered EH Received AIU Payment	*96.00%*	*94.74%*	*97.37%*	*97.37%*	*97.37%*	*97.37%*
EH Receive MU Stage 1 Payment	*61*	*61*	*72*	*72*	*72*	*72*
Successful AIU EH Received MU1 Payment	*84.72%*	*84.72%*	*97.30%*	*97.30%*	*97.30%*	*97.30%*
EH Receive MU Stage 2* Payment	*3*	*16*	*64*	*69*	*71*	*72*
Successful MU Stage 1 EH Received MU Stage 2 Payment	*4.92%*	*26.23%*	*88.89%*	*95.83%*	*98.61%*	*100.00%*
EH Receive MU Stage 3 Payment	*0*	*0*	*0*	*2*	*3*	*4*
Successful MU Stage 2 EH Received MU Stage 3 Payment	*0.00%*	*0.00%*	*0.00%*	*2.90%*	*4.23%*	*5.56%*

Data Source: AHCCCS EHR Team November, 2016

For Goal 2: Increasing Agency Use and Support for Health IT/HIE

The strategies identified under Goal 2 are all priorities under the Agency's DSRIP application that is currently pending with CMS. As part of that project the agency, will be evaluating integration for Behavorial Health Providers and Physical Health providers, Value Based Payment Projects, Care Collaboratives under AIHP, and Care for Children with Special Needs.

The table below is an example of a new contract requirement the Acute Care Plans are implementing to improve their performance related to e-Prescribing. The table below is a e-prescribing baseline of each plan and then a comparison to their one year later.

Table 26: E-prescribing and Health Plans

	Baseline January 1, 2014 - May 31, 2014	July 1, 2015 - Sep 30, 2015	Difference Baseline to QE September 30, 2015	Percentage Change
Acute	42.22%	46.17%	3.94%	9.34%
CARE 1ST ARIZONA	40.57%	45.41%	4.84%	11.92%
HEALTH CHOICE AZ	43.34%	42.82%	-0.52%	-1.20%
HEALTH NET ACCESS	34.58%	45.44%	10.85%	31.38%
MARICOPA HEALTH PLAN	39.67%	44.46%	4.80%	12.09%
MERCY CARE PLAN	40.06%	43.70%	3.64%	9.09%
PHOENIX HEALTH PLAN	40.16%	46.96%	6.79%	16.92%
UNITEDHEALTHCARE	43.70%	49.63%	5.93%	13.58%
UNIVERSITY FAMILY CARE	47.28%	51.15%	3.88%	8.20%
DHS BEHAVIORAL HEALTH	28.80%	48.02%	19.22%	66.73%
MERCY MARICOPA INTEGRATED	31.97%	45.32%	13.35%	41.76%
CMDP	46.57%	57.01%	10.44%	22.42%
CRS	41.82%	51.46%	9.64%	23.05%
DDD	44.03%	53.51%	9.48%	21.53%
LTC	23.76%	25.70%	1.94%	8.17%
BRIDGEWAY HLTH SOLUTION-L	20.70%	20.25%	-0.45%	-2.19%
MERCY CARE PLAN - LTC	23.49%	25.05%	1.56%	6.63%

UNITEDHEALTHCARE LTC	25.98%	29.72%	3.74%	14.41%

Data Source: AHCCCS DHCM, February 2016

For Goal 3: Accelerating Statewide HIE Participation for all Medicaid Providers and Plans, the agency will be tracking all of the HIE Annual Benchmarks which are displayed in Section E and include:

- Identifying all other payers and contributions to The Network
- Providing the Cumulative Number and % of total providers successfully connected annually
- The number and % of total Medicaid Covered lives with clinical data in The Network
- Status of HIE onboarding Program for Eligible Hospitals, broken down by milestones
- Status for HIE onboarding Program for FQHCS/Rural Health Centers broken down by milestones
- And new status of HIE Onboarding program for other Eligible Groups of Providers, broken down by milestone.

B.2 Future of AHCCCS IT System Architecture

(SMHP Companion Guide Question B #2)

SMA System Architecture 2020

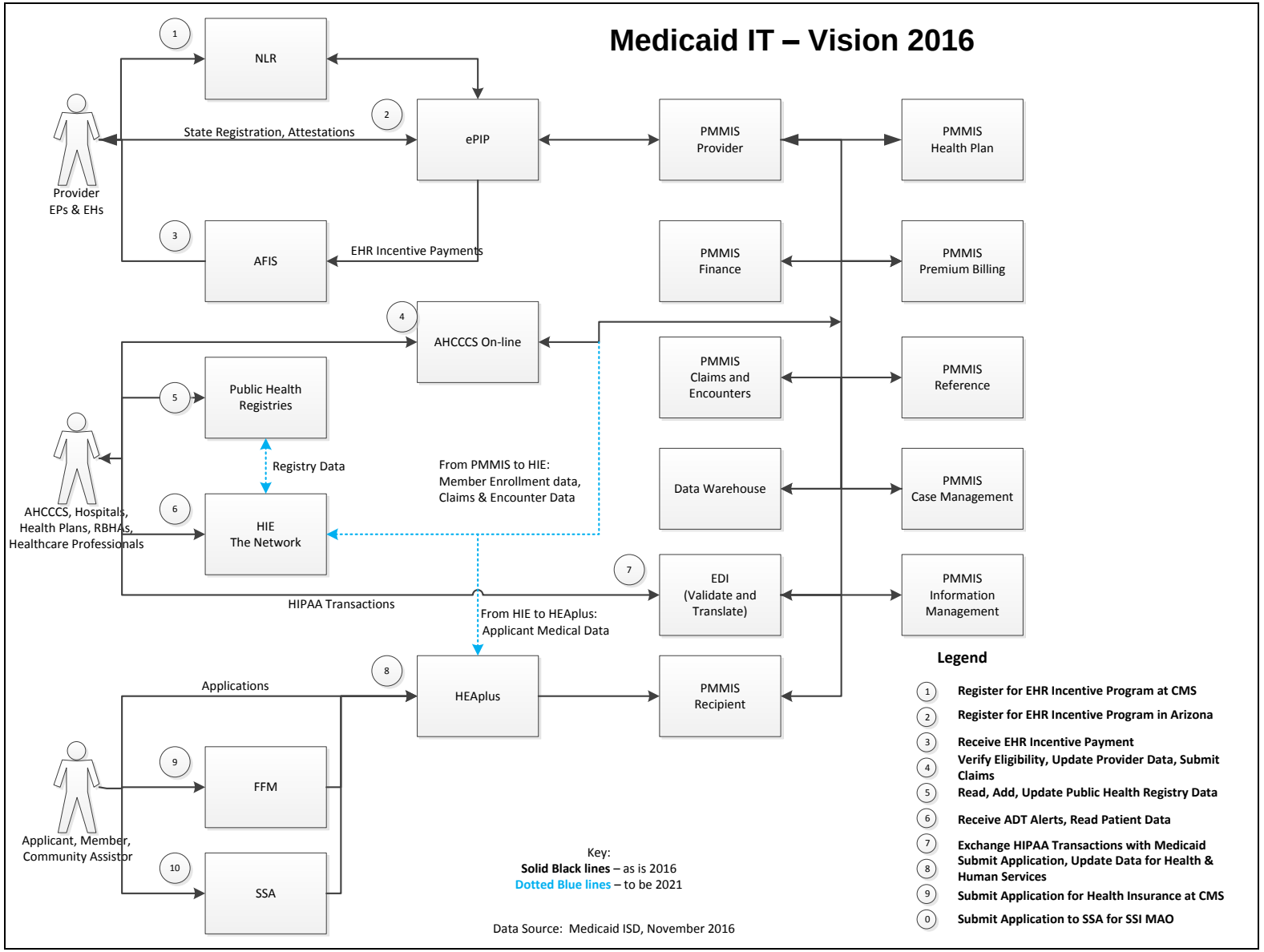
Long term, we expect AHCCCS and the contracted MCOs and RBHAs to utilize the HIE for care coordination of their Medicaid members and for clinical quality analysis. We expect Medicaid providers to utilize the HIE to better understand/assess their patients' medical health and to coordinate and share patients' health information with the patients and their other providers in an effort to improve patient health outcomes.

In the future, we expect AHCCCS to utilize the HIE to assist with the eligibility and enrollment for the Children's Rehabilitative Services Program (CRS).and in supporting member eligibility for the AHCCCS Long Term Care Program (ALTCS). In September 2016, the American Indian Health Program (AIHP) established connectivity with The Network to support the sharing of clinical data for care coordination. The AIHP is for members enrolled in the American Indian Health Plan which is operated by the AHCCCS Division of Fee for Service Management. Eventually, the agency would like to be able to use the HIE to assist with the determination of eligibility process for those members that rely on federal agency information coordination such as Social Security Administration (SSA) or Veterans Administration or Indian Health Services and Long Term Care.

The following diagram, in the figure below, highlights how the SMA IT system will support the AHCCCS long term goals and objectives of reducing costs, improving care coordination and improving health care outcomes. There are no plans at this time to combine the internet portals, enterprise service bus, master patient index or record locator services that are operated by the Network (HIE) with the agency's member eligibility process, Health-e-Arizona Plus, which uses similar technology.

Our vision shows that the Public Health Registries are connected to the HIE enabling providers to view and update their patient's registry data using their HIE connection. It also shows that the HIE is connected to AHCCCS using the web portal infrastructure with our MMIS which allows the Agency to more fully utilize the member health data available through the HIE. Lastly, it shows HEAplus connected with the HIE to access applicant healthcare information needed to support medical eligibility determination. All of these are beginning steps towards improving healthcare outcomes.

Figure 17: Integrated Medicaid IT Environment – Future Plans (2020 Vision)



Plans to leverage the State Level Repository (SLR) Beyond the EHR Incentive Program

Future plans include using the SLR (e-PIP) to pull MU-related data from the HIE for the EHR Incentive Program. During our MITA HITECH SS-A in 2016, the agency identified the need to coordinate agency planning closer with the MMIS and E & E initiatives already underway.

Medicaid Provider Interfaces with SMA IT System

AHCCCS hosts an on-line portal for providers where they can query eligibility and enrollment information about their patients. They may also enter and submit claims via the portal, and check on their claims status. Provider demographics may also be updated via the portal.

AHCCCS also hosts an EDI VPN connection for providers to submit batch HIPAA transactions for claims submission, claims status, and eligibility verification, and to receive the corresponding responses.

As discussed previously, AHCCCS also hosts the SLR portal, named ePIP, for the provider interface to the EHR Incentive Program.

Most Medicaid providers verify patient Medicaid eligibility and update their own provider demographics using one or more of these interfaces. To a lesser extent, Medicaid providers participate in the EHR Incentive Program. Medicaid providers with Fee for Service Medicaid members utilize one of the claim submission interfaces for electronic submission or they submit claims via paper.

State and Local Program Interfaces with SMA IT System

The following programs interface with the AHCCCS IT system many of which are part of the Medicaid eligibility determination process for both and acute and long term care members. There are other state agencies including the Department of Economic Security (DES) and the Arizona Department of Health Services/Division of Behavioral Health Services. Together these agencies and programs administer the following programs which interface with the SMA IT System:

- SNAP – Supplemental Nutrition Assistance Program
- TANF – Temporary Assistance for Needy Families
- BH - Behavioral Health
- SSI Cash – Supplemental Security Income
- SSI MAO – Supplemental Security Income Medical Assistance Only
- ALTCS - Arizona Long Term Care System
- FTW - Freedom to Work
- Children Program
- QMB - Qualified Medicare Beneficiary (Medicare Savings Program)
- SLMB - Specified Low-Income Medicare Beneficiary (Medicare Savings Program)
- QI - Qualified Individual (Medicare Savings Program)
- YATI - Young Adult Transitional Insurance (leaving foster care)
- Pregnant Woman Program

- BCCTP - Breast and Cervical Cancer Treatment Program
- Adult Program
- Parent and Caretaker Relative Program
- DDD – Division of Developmental Disabilities
- AHCCCS Medical Assistance

At this time, the AHCCCS IT system and its partners and functions are operated by State government and are separate from the state level health information exchange (The Network). The Network is housed outside of state government in a non-profit organization and state government collaborates with The Network, but does not manage or control its operations. Discussions are starting between AHCCCS programs and The Network to identify if any areas exist for streamlining operations, but as of now, the Network can only be used for "care coordination" and not other operational use cases.

B.3 Medicaid Providers Interface With the SMA Related to the EHR Incentive Program

(SMHP Companion Guide Question B #3)

Medicaid Provider Interface With The EHR Management System

All Medicaid Providers registered in the Medicaid EHR Incentive program have done so through the electronic Provider Incentive Payment System (ePIP). This system was developed and is maintained by SMA programmers. All eligible professionals and Medicaid-only hospitals report their MU data through ePIP; dually eligible hospitals report their MU data to CMS using the National Level Repository (NLR) which is shared with the States via the NLR – SLR (ePIP) interface.

As discussed previously, AHCCCS also hosts the SLR portal, named ePIP, for the provider interface to the EHR Incentive program.

Plans to Leverage the State Level Repository

The agency completed its agency wide MITA state self-assessment and completed the HITECH portion of the engagement. One of the findings called for greater collaboration between the MMIS and E & E systems at the agency with the HITECH program. Discussions are starting to ensure the agency develops a plan and strategy for leveraging the IT system as it relates to the EHR Incentive Program to see if it can be more integrated into the agency's overall business operations.

Part of the strategy discussion will include how to evaluate the quality and the robustness of the data elements that are captured through the electronic Provider Incentive Payment System (ePIP) and the Registration of EPs that want to participate in the EHR Incentive Program. Discussions are expected to occur across the agency to review how if possible any of the current standalone and possibly redundant systems can be integrated or closed in order to keep administration and upkeep of information to a minimum.

Another aspect of the MITA Assessment and the services and data that are available at The Network/HIE will help inform the SMA about how it can leverage any clinical data for provider and or health plan performance. At this time, none of the information being captured by an EHR is being used by the agency other than what is needed to qualify a provider for an incentive payment.

Medicaid Providers Accessing ePIP

Currently there are more than 5,190 Medicaid providers registered in ePIP. They are from the following Medical specialties:

- MD's/DO's
- Nurse Practitioners
- Certified Nurse Mid-wives
- Dentist's
- Physician Assistants

Local and State Programs Interfacing with ePIP

There are currently no local or state programs interfacing with ePIP other than the Medicaid EHR Incentive Program.

B.4 HIE Governance Planning and SMA HIT/HIE Goals and Objectives

(SMHP Companion Guide Question B #4)

HIE Governance Structure

In Arizona, the HIE governance structure is currently in place at Arizona Health-e Connection, which serves as a public/private non-profit organization. Since 2007 there has been a Board of Directors which has 4 state agencies as permanent members. The Medicaid Agency is one of those permanent members as is the Arizona Department of Health Services, the Governor's Office and the Arizona Department of Administration. The full board is comprised of multiple organizations including employers, universities, reference labs, a health care quality organization, Long Term Care providers, Behavioral Health providers, hospitals, providers, health plans and a Federally Qualified Health Center members among others. The SMA believes this is the appropriate HIE governance structure that needs to be in place now and in the future to achieve the SMA HIT/HIE goals and objectives.

By the end of 2015, the Health Information Network of Arizona (HINAz) Board was dissolved and merged fully with Arizona Health-e Connection to improve efficiencies and provide full management oversight of the state level HIE called "The Network". AzHeC has kept a Network Leadership Council which has participants with deep technical expertise to advise The Network on its implementation plans.

The current Arizona Health-e Connection Board is detailed in the following table:

Table 27: AzHeC Board of Directors

Arizona Health-e Connection
Advancing health and wellness through information technology

2016 Board of Directors

	Board Allocation	Board Organization	Board Member
Permanent Members	The Governor of Arizona	Governor's Office	Christina Corieri, Policy Advisor Health & Human Services
	Arizona Health Care Cost Containment System (AHCCCS)	AHCCCS	Thomas J. Betlach, Director
	Arizona Department of Health Services (ADHS)	ADHS	Janet Mullen, Deputy Director
	Arizona Department of Administration (ADOA)	ADOA	Vacant
	Arizona Hospital & Healthcare Association (AzHHA)	AzHHA	Greg Vigdor, President & CEO
	Arizona Medical Association (ArMA)	ArMA	Pele Peacock, Vice President, Policy & Political Affairs
	Arizona Osteopathic Medical Association (AOMA)	AOMA	Peter Wertheim, Executive Director
Non-Permanent Members	Health Plans	Blue Cross Blue Shield of Arizona	Garrett Anderson, Vice President & CTO
		Cenpatico Integrated Care	Sloane Steele, Sr. Vice President, Business Systems & Data Management
		Cigna	John Parente, MD, CMIO
		Mercy Care Plan	Mark Fisher, CEO
		UnitedHealthcare	Karen Saelens, COO, UHC Community Plan
	Hospitals	Abrazo Community Health Network	Michele Finney, CEO
		Banner Health	Ryan Smith, Senior VP & CIO
		Benson Hospital	Rob Roberts, IT Director
		Carondelet Health Network	Amy Beiter, MD, CEO, St. Mary's Hospital
		Dignity Health	Sean Turner, Sr. Director, Interoperability & Population Health
		HonorHealth	Richard Silver, MD, Senior VP, Population Health & Executive CMO
		Yavapai Regional Medical Center	Tim Roberts, CIO
	Higher Education Institution	Arizona State University	William G. Johnson, PhD, Professor, Biomedical Informatics
	Laboratory	Sonora Quest Laboratories	David Dexter, President & CEO
	Pharmacy	Arizona Pharmacy Association	Kelly Fine, CEO

AzHeC Board of Directors (continued)

	At-Large	Arizona Alliance of Community Health Centers	John McDonald, CEO
		Arizona Health Care Association	Kathleen Collins Pagels, Executive Director
		Arizona Nurse Practitioners Council	Erich Widemark, PhD, Director of Simulation Education, University of Phoenix
		Cardiovascular Consultants	Andrei Damian, MD, President
		District Medical Group	Jeff Weil, CIO
		El Rio Community Health Center	Nancy Johnson, CEO
		Health Information Management Systems	Khalid Al-Maskari, CEO
		Health Services Advisory Group	Mary Ellen Dalton, CEO
		Independent Healthcare Consultant	Tony Fonze
		Maricopa County Correctional Health	Jeff Alvarez, MD, Director
		Mountain Park Health Center	Bill Kirkland, Data Manager
		Regional Center for Border Health	Philip Gladney, Director of Information Technology
		University of Arizona, College of Medicine	Ronald Weinstein, MD, Founding Director, Arizona Telemedicine Program

Data Source: Arizona Health-e Connection May 2016

Current HIT/HIE Initiatives Supporting SMA Program Management, Population Health Management and Potential Funding Requirements

Within the next 3 – 5 years the agency anticipates it will be facilitating access to infrastructure to support projects that ensure state level data access and analysis. The infrastructure will be implemented incrementally over five years with information technology that focuses on improving health information sharing, protocol development and analytics. The agency is considering a variety of funding mechanisms to ensure this can be created. The agency is participating in discussions and review of population health and data analytic tools and services that The Network is engaged in with all of its stakeholders. The agency is evaluating HITECH funds, MMIS and E & E funding plus the use of other funds such as DSRIP to see which funds would be most appropriate for request.

The EHR Incentive Program is setting the stage for more complete and complex clinical data sharing by increasing the number of Providers that are adopting and using EHRs. Once the providers are using them, they will be more likely to participate in Health Information Exchange. When EHRs are more widespread the agency will be able to ask its health plans to evaluate and measure provider's quality of care and experiment with paying for Episodes of Care vs in a

Fee for Service model. AHCCCS and the Division of Behavioral Health Services were integrated as of July, 2016 and will support our goal of reducing fragmentation between physical health providers and behavioral health providers.

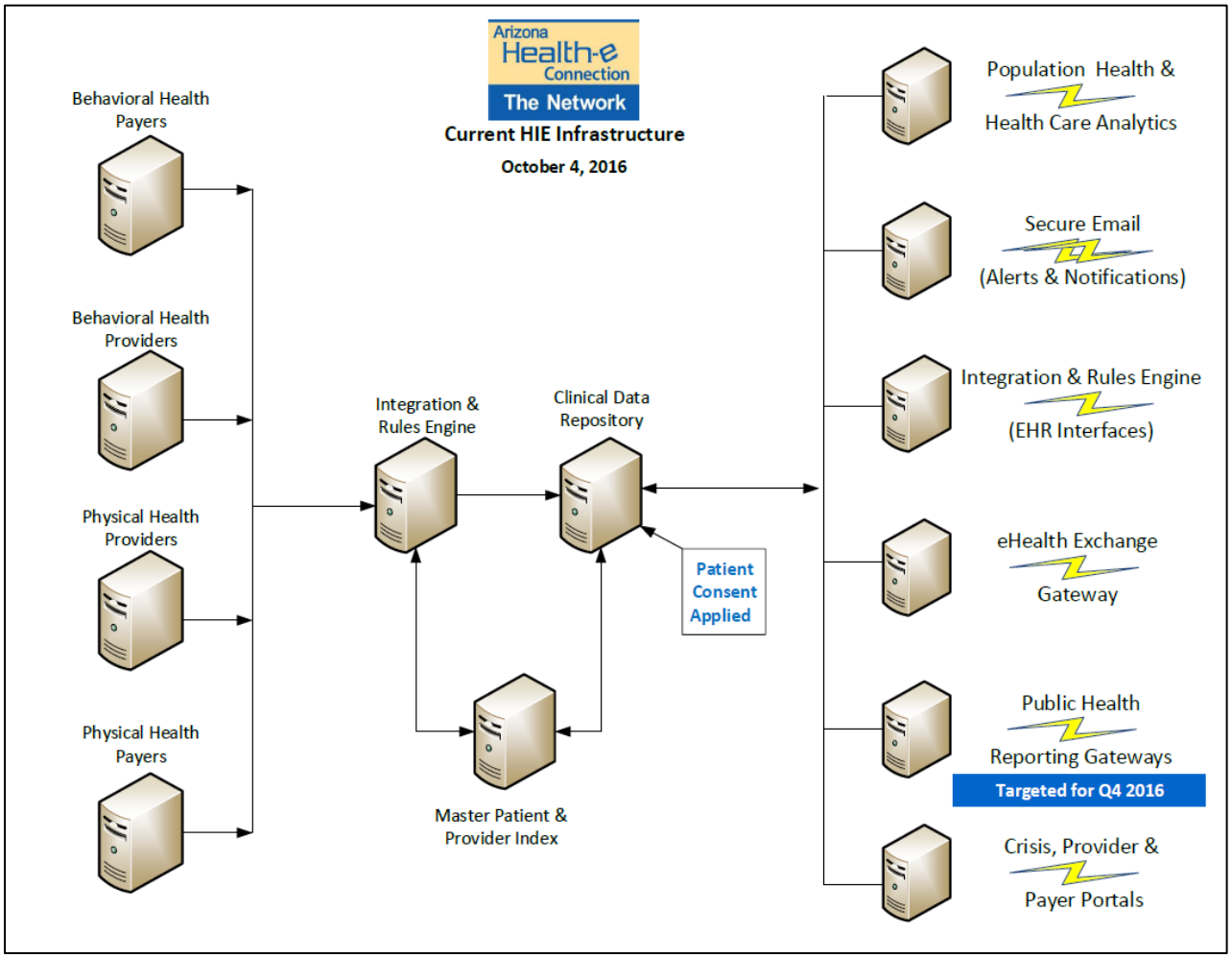
As the data becomes more available through The Network, it is expected that each Managed Care Organization will develop a population health management approach by being able to receive and analyze more timely clinical data from its membership. The improved quality of the data is allowing the SMA and its plans to more closely monitor the quality of the care that is being delivered and tying the outcomes of the care to its payment reform strategies.

Over time the Arizona Department of Health Services will continue to lead efforts for creating state population health analytics with The Network.

The figure below is a visual of The Network's participants and how they will access the Public Health Reporting Gateway and how all community providers can connect to The Network.

AHCCCS will be submitting a complete HITECH IAPD shortly but expects to request funding for administrative expenses, Health Information Technology Education, and Health Information Exchange funds for onboarding of Medicaid providers. At this time the agency expects to request $4.2 million for HIE onboarding.

Figure 18: HIE Current and Future Support of Population Management (2016)



Data Source: Health Information Network of Arizona (The Network) October 2016

B.5 Steps SMA will take in next 12 months to Encourage Provider Adoption of Certified EHRS technology?

(SMHP Companion Guide Question B #5)

Describe changes that have been implemented for the Medicaid Expansion

According to the SMAs Network Operations area, while there has been member growth in the Medicaid program and there has been some provider growth associated with the General Mental Health/Substance Abuse dual integration, there has not been a very significant increase in the number of providers in the MCO Networks. The MCOS are focused on moving members into Value Based Payment and Accountable Care arrangements, which has actually driven down the number of providers as health outcomes and provider performance are heavily reviewed.

Encourage Adoption of Certified EHR

AHCCCS is continuing to pursue several internal initiatives to encourage provider adoption of certified EHR:

- Through its Business Intelligence Unit, AHCCCS has identified Eligible Professionals who have not registered for the EHR Incentive program and may be eligible based on patient volumes.
- AHCCCS has contracted with AzHeC to perform education and outreach webinars, phone contacts and emails to enrolled or eligible providers to increase the number of EPs that participate in the EHR program and to provide support for providers registered in the EHR Incentive Program that are not progressing to the next stage of Meaningful Use. As part of that contract the agency:
- AHCCCS discusses the outcomes of its outreach strategy monthly when it reviews the status reports received from AzHeC.
- AHCCCS has expanded the scope of work for education and recruitment to include dentists.
- AHCCCS has expanded the scope of work for its technical consultant (AzHeC) to include education and outreach to improve baseline e-prescribing rates.
- AzHeC provides for both on-site and remote (phone/WebEx/e-mail) provider consults for those providers attempting to obtain AIU or progress through various stages of meaningful use.
- AHCCCS expanded the HIE onboarding subsidy to include physician practices, facilitating the completion of MU objective 5, health information exchange and ability to share a summary of care record for each transition of care or referral.
- AHCCCS communicated with the SMAs program contractors (Managed Care Organizations) to also reach out to its high volume providers that are not participating and encouraged them to contact AzHeC and get enrolled in the EHR Incentive Program.

- AHCCCS is in the process of updating all of its educational materials for EPs and posting them to the web. Attestation guides and Patient Volume Estimation tools have been updated. An AIU Quick Reference Guide has been created and posted to the website along with an updated full guide.
- AHCCCS performed an online survey of those EPs that received a payment from the EHR Program in 2015. Based on the feedback, AHCCCS increased its staffing to improve its customer service experience for the EP.
- The agency is working to automate some parts of the ePIP administrative portal in order to decrease the amount of manual analysis and processes to speed attestation processing.
- AHCCCS has hired an additional IT programmer to help with the ePIP portal updates and to keep it HIPAA compliant.
- AHCCCS is working to have The Network and the Arizona Department of Health Services complete their HIE discussions to allow providers to use the Mirth public health reporting gateways as a way to automate MU submissions. A pilot for provider submissions of immunization data to Public Health through the HIE is currently underway to ensure data can be shared.

Complete Description of strategies being adopted to Leverage Health IT Investments to Reduce Fragmentation and Improve Care Coordination

Below is a comprehensive listing of all of the strategies the SMA has adopted to encourage provider adoption of EHRs, outreach strategies to move providers to MU, HIE participation as plans to maximize AIU, MU and interoperability through 2016.

Goal 1: Oversee and Administer the EHR Incentive Program

Strategy 1A - Ensure Providers Migrate Through the MU Continuum
1. Encourage Medicaid providers to adopt, implement, or upgrade to CEHRT
2. Implement and maintain electronic Provider Incentive Payment System (ePIP)
3. Enhance the functionality of e-PIP to be more automated for the administration of the EHR program
4. Implement and maintain communications, materials and tools for providers and members
5. Perform Education and Outreach for eligible but unenrolled providers
6. Partner with program contractors to identify high volume providers that need to register and attest to the MU program.
7. Develop and maintain Policies and Procedures documentation
8. Process provider registrations, attestations and payments
9. Conduct payment audits
10. Report results of the EHR Incentive Program performance to stakeholders
11. Conduct provider surveys to determine the impact of the EHR program
12. Participate in CMS led trainings including Communities of Practice (CoPs), All-States CMS Calls, and HIT-related conferences and events
13. Develop and update State Medicaid HIT Plan (SMHP) and HIT funding documents
14. Use agency MITA State Self-Assessment findings to build HITECH Program planning
Strategy 1B - Support ADHS Public Health Onboarding for Meaningful Use Measures

1. Support onboarding of providers to the HIE in order to access and send information through the electronic Public Health Gateway and ADHS MU Coalition.
2. As appropriate, request HITECH IAPD funds for establishment of ADHS infrastructure for Gateways
3. Collaborate with ADHS to develop a long term plan for using the HIE to enhance public health reporting for Medicaid providers

Strategy 1C - Achieve Program Integrity Plan Goals

1. Ensure Agency has engaged Audit Subject Matter Experts (SMEs) to support the review and implementation of Agency EHR Audit program
2. Update and submit to CMS a new AHCCCS EHR Program Audit Strategy as needed
3. Participate in CMS sponsored Community of Practice for Program Integrity
4. Increase frequency of provider audits and provide audit training as appropriate to providers

Goal 2: Increase Agency Use and Support for HIT/HIE

Strategy 2A- Support Care Coordination and Integration Between Physical and Behavioral Health Providers

1. Monitor the progress of the Statewide HIE Integration Plan (SHIP) that calls for connectivity between the HIE and the top 100 behavioral health providers
2. Recruit any eligible Behavioral Health providers that qualify to the EHR incentive program
3. By July 2017, expand the current HITECH IAPD language to allow for HIE onboarding for non EHR Eligible Medicaid Providers that enable eligible providers can meet MU.

Strategy 2B – Support AHCCCS Payment Modernization Initiatives and Administrative Efficiency Projects

1. Participate in the CMS led Healthcare Payment Learning & Action Network (LAN) to identify opportunities to link alternate payment reform efforts with Health IT/HIE milestones and measures
2. Working across the agency, update the agency's roadmap for data sharing and Clinical Quality reporting that leverages new electronic reporting tools and services.

Strategy 2C –Implement American Indian Medical Home Waiver (AIHP)

1. 1 Support Indian Health Service (IHS)/Tribal 638 primary care site transformation into Patient – Centered Medical Homes (PCMH)
2. Develop care management systems for American Indian populations enrolled in AIHP and receiving services through IHS/Tribal 638 providers and non-IHS/Tribal 638 providers.
3. Develop a data infrastructure that can support data analytics using both clinical data and claims data for providers serving AIHP members.
4. 4. Reduce fragmentation of care among IHS/Tribal 638 and non-IHS/Tribal 638 providers serving AIHP members through regional Care Management Collaboratives that improve outcomes for AIHP members

Strategy 2D –Improve Justice System Transitions

1. Develop an integrated health care setting within county probation offices or Department of Corrections parole offices to address beneficiary health care needs upon release and throughout the term of probation/parole for individuals transitioning out of incarceration.
2. Ensure the county and state correctional entities have signed a Participation Agreement with the HIE.
3. Participate in planning to ensure that Medication History becomes more readily available through the HIE to appropriate providers
4. Over the next 2 – 3 years improve member engagement by increasing transparency and education for justice involved members

Strategy 2E- Improve Care for Children with Behavioral Health Needs including Those at Risk and Engaged in the Child Welfare System

1. Support the integration of behavioral health and primary care services for children in both primary care sites and community behavioral health sites.
2. Improve treatment for the care of children with and at risk for Autism Spectrum Disorder (ASD)
3. Improve treatment for the care of children engaged in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child welfare system, by developing electronic connectivity between providers at the HIE.

Strategy 2 F- Continue Agency Participation in Qualified HIE for Governance, Policy Making and IT Service Offerings

1. Ensure executive participation on the nonprofit Health IT Board of Directors
2. Monitor and support the growth of the state HIE by monitoring all HIE services and delivery of benchmarks to AHCCCS and its stakeholders

Goal 3: Accelerate Statewide HIE Participation by All Medicaid Providers and Plans

Strategy 3A – Expand the HIE Onboarding Program for Medicaid Hospitals, FQHCS, Groups and All Other Medicaid Providers
1. Using federally approved 90/10 HITECH funds, identify eligible providers for the HIE onboarding program to accelerate bidirectional data flows between participating organizations. 2. Claim 90/10 HITECH funds that include HIE onboarding funds for all other ineligible Medicaid providers as long as they support an eligible provider demonstrate MU – (SMD#16-003). 3. Track and monitor HIE onboarding milestones and payments
Strategy 3B- Support Increased Health Plan Use of HIE to Improve Health Outcomes and Clinical Quality Measures
1. Identify opportunities to improve administrative efficiencies with the agency and the plans related to HIE functionality and services. 2. Work with the Health Plan Association to implement an e prescribing campaign for the MCOs by Q1 2017
Strategy 3C- Seek Alternative Funding for Non Participating Providers
1. Participate in researching other federal grants for Health IT related funding opportunities 2. Working with stakeholders, participate in local foundation or community based funding opportunities to maximize number and type of provides that can participate in Health IT/HIE programs.
Strategy 3D- Coordinate Other State and Federal Agencies' Participation in HIE
1. Work with state agencies to coordinate implementation of public health meaningful use measures and other registries that can improve and inform long term population health management 2. Monitor the integration of the Controlled Substance Prescription Drug Monitoring Program (CSPMP) with the HIE to ensure providers can seamlessly access drug information 3. Through the State HIT Coordinator, initiate discussions with other state agencies to educate them about health information exchange and health information technology initiatives 4. Monitor the progress of the Health–e Way Certification/Sequoia Project to ensure the participation of targeted Federal Agencies' in the HIE

11/17/2016

HIE Participation and Adoption of EHR by Non-Eligible Provider Types

Integrating health care delivery between behavioral health and physical health providers is an agency priority. Starting in July, 2016, through the Regional Behavioral Health Plans, funds were made available for behavioral health providers to onboard to The Network. That work is underway and is expected to connect up to 65 unique behavioral health providers by the end of June, 2017. These funds are NON- HITECH funds.

Through the release of the new State Medicaid Directors letter (SMD # 16-003) AHCCCS expects to encourage HIE onboarding to The Network for other non-eligible provider types. AHCCCS is requesting permission from CMS through this SMHP to request permission to subsidize health information exchange (HIE) onboarding by "…developing connectivity between Eligible Providers (whether eligible professionals or eligible hospitals) and other Medicaid

providers if this will help the Eligible providers demonstrate Meaningful Use." AHCCCS expects to use this funding authority to onboard long term care providers, or any other Medicaid provider.

The agency completed the Health IT Plan that was one of the components of the State Innovation Model or SIM Design Grant. The Health IT plan recommended establishing HIE connectivity among the key participants that are focused on coordinating care for three unique populations: (1) for the American Indian Health Program, (2) for the individuals that are involved with the county and state justice system, and (3) for the organizations that are implementing integrated behavioral health and physical health delivery.

Starting in early 2015, The Network moved to a new HIE platform with MIRTH, which offered robust functionality that had previously been missing from its earlier vendor. The new technology was able to offer alerts and accelerated the interest of a variety of organizations to connect to The Network. At the end of 2015 there were 78 participants, double the number from the year end of 2014 where there were only 33.

As of November of 2016, The Network has 224 different organizations participating with it. (See table below.) A full listing of participants is included in Appendix F:7.

(Section B.5 Continued)

Table 28: The Success of The Network Growth Through November 2016

Major HIE Participant Groups	2011 YE	2012 YE	2013 YE	2014 YE	2015 YE	2016 YTD
All Participants	11	23	33	33	78	224
FQHCs/RHCs	1	2	2	2	13	21
Community Providers	1	5	6	6	20	62
Behavioral Health Providers	0	0	0	0	10	69
Hospitals and Health Systems	5	7	11	11	14	22
Health Plans and Payers	2	6	6	5	11	13
Long Term and Post-Acute Care						11
State and Local Government						14
Accountable Care Organizations						8
Health Information Exchanges						2
Labs and Imaging Centers						2

Data Source: Arizona Health-e Connection, November, 2016

Describe changes that have been implemented for the Medicaid Expansion-

According to the SMAs Network Operations area, while there has been member growth in the Medicaid program and there has been some provider growth associated with the General Mental Health/Substance Abuse dual integration, there has not been a very significant increase in the number of providers in the MCO Networks. The MCOS are focused on moving members into Value Based Payment and Accountable Care arrangements, which has actually driven down the number of providers as health outcomes and provider performance are heavily reviewed.

B.6 SMA Encouragement of FQHC EHR Adoption

(SMHP Companion Guide Question B #6)

FQHC's and HRSA Funding

At this time, the SMA is not aware of any current specific HIT funds that have gone out to the FQHCs from HRSA for HIT adoption since 2011 or 2012. Many of the FQHCs and RHCs have had their EPs apply for EHR Incentive Payments and a complete list of those facilities and the number of their EPs that have attested is in Section A.3.

AHCCCS does have an HIE onboarding program that incentivizes Eligible Hospitals, FQHCs and Rural Health Centers (RHCs) to join the Network. At this time 18 FQHCs/RHCs have received a milestone payment for joining the HIE and 11 have received a milestone payment for establishing a one way interface for data sharing.

Table 29: FQHC HIE Onboarding

FQHS and Rural Health Centers		Milestones				
		#1	#2	#3	#4	#5
Adelante Healthcare, Inc.	FQHC	✓				
Canyonlands Community Health Care	FQHC	✓	✓			
Chiricahua Community Health Centers	FQHC	✓				
Desert Senita Community Health Center	FQHC	✓	✓			
El Rio Health Center	FQHC	✓	✓			
Horizon Health and Wellness	FQHC	✓	✓			
Marana Health Center, Inc.	FQHC	✓				
Maricopa County Health Care for the Homeless	FQHC	✓				
Maricopa Integrated Health Systems Clinics	FQHC	✓	✓			
Mariposa Community Health Center, Inc.	FQHC	✓	✓	✓	✓	
Mountain Park Health Center	FQHC	✓	✓			
North Country HealthCare	FQHC	✓	✓			
Sun Life Family Health Center	FQHC	✓				
Sunset Community Health Center	FQHC	✓	✓			
United Community Health Center, Inc.	FQHC	✓	✓			
Wesley Community Center	FQHC	✓				
St. Elizabeth's Health Center	FQHC	✓				
San Luis Walk-In Clinic	RHC	✓	✓			

Data Source: AHCCCS Invoice Tracking, October, 2016

B.7 How will the SMA assess or provide Technical Assistance for Medicaid Providers

(SMHP Companion Guide Question B #7)

Eligible Providers Technical Assistance

The agency provides ongoing help to providers through phone calls and webinars to educate them about the EHR incentive program, how to attest and the MU requirements. The EHR team has created three different education tools or guides for providers to refer to for AIU, Registration and Attestation all of which are free and on the agency website.

For eligible professionals, Through the agency's online survey project where it queried existing participants, feedback was received that identified what time of day providers would want to engage in technical assistance and also what their preference was for communicating with the agency. Workflows are being reviewed to see how the SMA can more quickly review and approve attestations, and respond to eligible professional questions.

The agency has a contract with Arizona Health-e Connection to provide recruitment of potentially eligible professionals to the EHR Program through mailings, phone calls, webinars and marketing to the approximately 700 EPs that who appear to be eligible for the program, that have not registered yet. AzHeC is reaching out and gathering data about any barriers the unenrolled EPs are experiencing to see if the SMA can address with them.

Challenges to Overcome and Lessons Learned

According to summaries gathered from providers that were awarded grant funds under the ONC State HIE Cooperative Agreement Program (SHIECAP) several barriers and common problems were encountered as they worked to adopt CEHRT and implemented transport and exchange options. Several of these "lessons learned" are listed below and are included in the agency's strategy to improve adoption of Health IT:

- Sometimes there may not be an immediate Return on Investment (ROI) for the participant for EHR adoption and HIE participation.
- Currently there is a lack of readily available, affordable technology support for some providers throughout the technology adoption and implementation cycle.
- The time involved in planning and implementing the HIT/HIE technology and strategy took longer and was more complex than many providers originally had expected.
- Implementation of both HIT and HIE took a very focused and ongoing commitment from providers and staff with many providers needing to supplement staff doing the work with subject matter experts.
- The EHR vendor community has been challenged to deliver the required software changes to make all of the MU Program changes in a timely fashion.

- Because each provider workflow is unique, it can be challenging to make large scale replicable implementations work – each implementation was unique making the rate of adoption slower than in other types of implementation projects.

- The SMA believes that in order to move towards care improvement and cost reduction, clinical information needs to flow freely across networks and between providers. For this reason, ensuring that certified EHR systems can be interoperable with the state level HIE, is an important priority.

Expanding CEHRT Adoption to Behavioral Health, LTC for adoption of CEHRT and movement by EPs/ EHs through the MU stages and Participation in HIE by All

The State of Arizona does not have any state dollars funded or non-HITECH dollars to purchase EHRs for non-eligible EPs or EHs. A limited number of state dollars have been made available to certain behavioral health providers to connect to the HIE, not to buy EHRs. However, due to such a competitive business environment in our state many EPs and Long Term Care facilities and BH providers are using their own resources or the resources of an ACO or Health Plan to implement CEHRT. These purchase and implementations of CEHRT are not being performed by the SMA.

If the organization or entity is not eligible for the Medicare or Medicaid EHR Incentive Program, then the organizations are not working with the SMA to meet MU measures or stages. The HIE is going out and actively recruiting a variety of health care participants to ensure the HIE and the data it provides is robust and of high value to all of its participants.

As noted in Table 24 in Section B.5, the HIE is experiencing significant and continuous growth. The HIE has adopted a new platform (Mirth) and has expanded both its service offerings, use cases and the volume and type of providers served.

Beyond acute care hospitals, Critical Access Hospitals and FQHC's, RHC's, participant types have expanded to include:

- *Community Providers,*
- *Behavioral Health Providers,*
- *Health Plans and Payers*

Year to date, active participants have grown to 217 with 6.2 million unique patients representing 90% of Arizona beds.

As authorized by SMD #16-003, the SMA will be pursuing a wider variety of Medicaid providers for participation in the HIE in the next FFY.

B.8 SMA Management of Populations with Unique Needs

(SMHP Companion Guide Question B #8)

Serving Populations With Unique Needs

Internally, AHCCCS will be monitoring the number and type of providers (including FQHC, IHS and VA providers and pediatricians and dentists) that are successful in receiving a payment through the incentive program as well as hearing about any barriers or challenges EPs may be having through monthly teleconferences with AzHeC.

Through the Agency's HIT Steering Committee, each of the AHCCCS-covered populations is represented. The Assistant Directors from the Division of Health Care Management and Fee for Service Management are taking the leads in care coordination for behavioral health, dual eligibles and Children's Rehabilitative Services (CRS). At this time the SMA is expected to reach its goal of ensuring that 700 Pediatricians are participating in the EHRs incentive Program.

In future years, the Meaningful Use criteria may address children's issues and include more of a focus on improving the quality of preventive healthcare for children. AHCCCS will work with ADHS and AHRQ to ensure that data and reporting efforts are targeted on improved clinical outcomes. AHCCCS continues to monitor member coverage via the providers participating in the EHR Incentive Program to determine how comprehensive the Meaningful Use data is for measuring quality of care and where more information is needed. At this time, AHCCCS does not believe that the data would accurately reflect the population served; however, ongoing efforts continue to ensure the Meaningful Use of EHRs in order to increase the accuracy and availability of electronic clinical quality data.

The agency added staff to manage clinical quality reporting in its Division of Health Care Management and this person helps staff a clinical reporting workgroup made up of representatives from AHCCCS health plans.

B.9 Grant Leverage of the EHR Incentive Program

(SMHP Companion Guide Question B #9)

HIT Related Grant Management-

The agency had multiple grant projects running with Arizona Health-e Connection and each of them will help inform the SMA about how to ensure that its stakeholders are participating and maximizing the value of the health IT tools, like EHRs and the Network/HIE.

Project 1: State Innovation Model (SIM) Planning Grant - The agency received a SIM Model Design planning grant which identified gaps or challenges providers have when trying to share or provide real time clinical quality data in a transformational plan that assessed different payment and care delivery models that improve the patient experience (including quality and satisfaction), improve the population health and reduce per capita costs of healthcare in the strategic focus areas below:

1. Enhance coordination and integration between Physical Health and Behavioral Health Providers for adults and children.

2. Improve justice system transitions through development of HIT/HIE infrastructure and health plan interfaces to coordinate coverage and care with Arizona Department of Corrections (ADOC), county jails and probation systems.

3. Enhance and develop regionally based care coordination models for the American Indian Health Plan (AIHP) members, including data sharing capacity, collaboration with Indian Health Services, 638 Tribally operated, and non-tribal providers to support provider infrastructure development and reduced delivery system fragmentation.

One of the deliverables of the SIM transformation plan was a Health IT plan that will support communications and real time data exchange among the EPs that make up the care network for each of the 3 target populations. Arizona Health-e Connection hosted and coordinated stakeholder engagement activities needed to develop the Health IT components of the SIM grant.

Project 2: Statewide BH-PH Integration (SHIP Plan) - Arizona Health-e Connection was tasked by the State of Arizona to produce an integrated Physical and Behavioral Health Plan for HIE. The Network has begun the development of a statewide plan to integrate physical and behavioral health information exchange under one infrastructure. The goal is to improve quality and outcomes for Arizona patients who receive physical and behavioral health care. The state level HIE model needs to support providers in developing integrated service delivery models and must contain these essential elements:

- A single HIE infrastructure managed by the Network
- One marketing and communication and messaging strategy for the Integrated HIE for all physical and behavioral services; and
- One financial model that encompasses a single fee for physical and behavioral health care stakeholders to sustain the integrated physical and behavioral health network

This plan was delivered to AHCCCS and there is a list of the top 100 BH providers that have been connected to The Network in Appendix F.6.

Project 3: Arizona Health-e Connection was awarded a Transforming Clinical Practice Initiative Grant (TCPI) - The grant was awarded September 29, 2015. It is a collaboration of AzHeC, Mercy Care Health Plan and Mercy Maricopa Integrated Care Organization. It is expected that AHCCCS providers will be able to receive coaching and technology tools and workflow redesign to transform the way they provide care and to prepare them for Value Based Purchasing (VBP). Many of the EPs that have just gotten an AIU payment are interested in learning more about how they will need to make practice work flow changes to enable them to get the maximum value out of the new tools they have implemented.

Project 4: Testing Experience and Functional Tools Grant (TEFT) - TEFT – Testing Experience and Functional Tools Grant-was awarded April of 2014. The purpose of the grant is to further adult quality measurement activities under Section 2701 of the ACA (PPACA). The CMS strategy for implementing the section is to support the SMA in collecting and reporting on the Adult Core Measures. This tool is primarily intended to test the collection of adult quality measures for use in Medicaid community based long term services and support (CB- LTSS)

This grant also gives states the opportunity to use web based personal health records (PHR) systems, subject to beneficiaries permission, as a vehicle for capturing testing and reporting on state quality measures and other related quality information. Arizona has elected to participate in 2 of the 4 components of the TEFT grant which include:

1. Field Test a beneficiary survey,
2. Field Test a modified set of continuity assessment record and evaluation of functional assessment measures At this time the grant is being managed by the Office of the Medical Director. The HIT Coordinator and HIT Project Manager are a part of the grant steering committee. At this time the HIT pieces are being identified with the grant consultants.

B.10 SMA Need for New or Changed State Laws

(SMHP Companion Guide Question B #10)

Anticipate the Need for New or Changed State Legislation

In the last two legislative sessions there has been activity that has addressed substance abuse by requiring AHCCCS contractors to intervene if someone receives more than 10 prescriptions in a 3 month period (SB 1032) and requires the Board of Pharmacy to provide access to the Controlled Substance Prescription Monitoring Program (CSPMP) to prescribers licensed under the Controlled Substances Act. (SB 1370) In 2016, Senate Bill 1283 passed which requires all prescribers to access the CSPMP before prescribing opioids.

AHCCCS is working with the Board of Pharmacy to identify it's interest in joining Arizona Health-e Connection and having its data be a part of The Network and/or through participation as a specialized registry as part of the MU Program.

B.11 SMA Need for Issue Management and Other Institution Involvement for Five Year Goal realization

(SMHP Companion Guide Question B #11)

Other Issue Management and Interoperability Arrangements

The agency is committed to pursuing different payment reforms over the course of the next five years and has updated its new 1115 Waiver application to CMS to include cost sharing and expects its Medicaid Health Plans to be embracing technology for themselves and their members in order to reduce costs and improve health outcomes. Getting value out of the current care delivery system is a high priority.

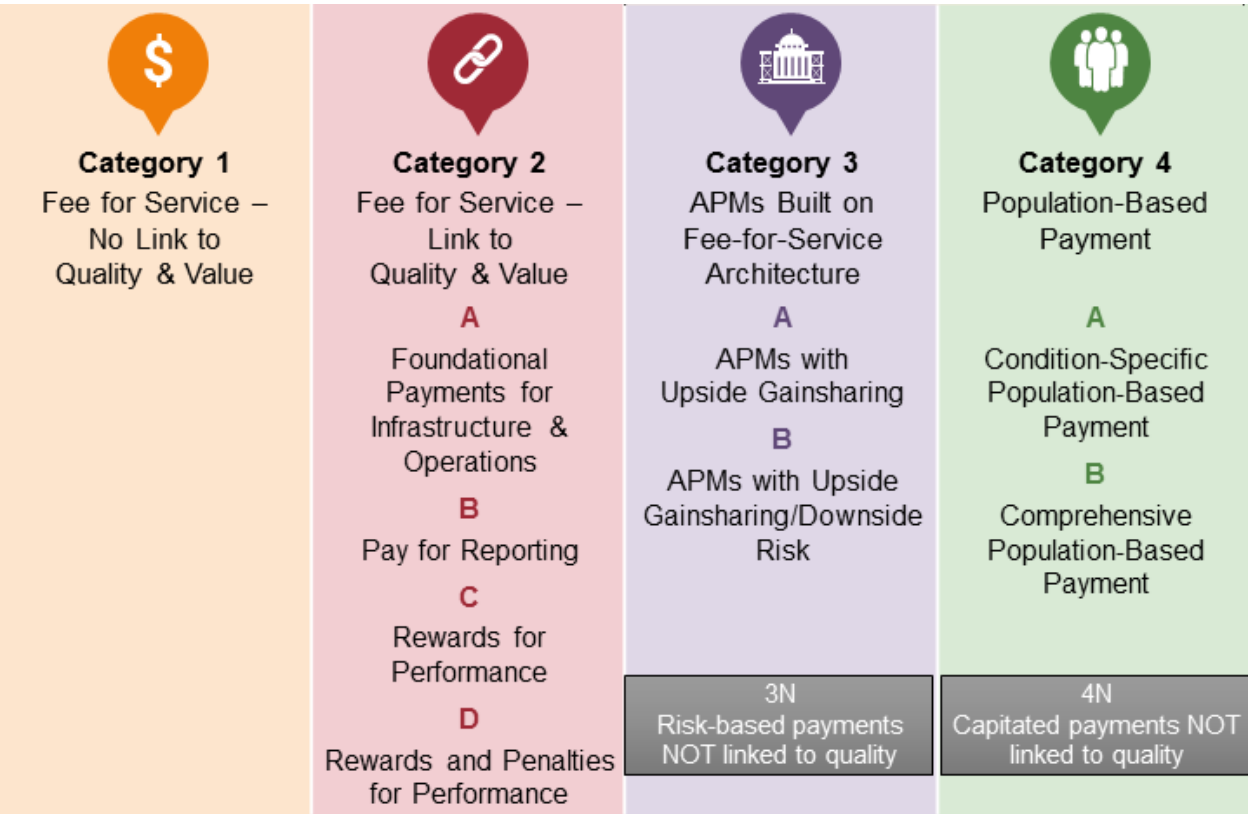
AHCCCS joined the CMS sponsored Health Care Payment Learning & Action Network (LAN) in 2016, which was created to drive alignment in payment approaches across the public and private sectors of the US Helath care system. This group has created the Alternative Payment Models Framework which is represented below.

The APM Framework rests on seven principles :

1. Changing proiders' financial incentives is not sufficient to achieve person centre care so must also empower patients to be partners in health caer transformation.
2. The goal for payment reform is to shift US healthcare spending significantly towards population based (and more person focused) payments.
3. Value based incentives should ideally reach the providers that deliver care.
4. Payment models that do not take quality into account are not considered APMs and do not count toward payment reform.
5. Value based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.
6. APMs (Alternative Payment Models) will be classified according to the dominant form of payment when more than one type of payment is used.
7. Centers of Excellence, Accountable Care Organizations, and Patient Centred Medical Homes are examples, rather than Categories in the APM Framework because they are dlivery systems that can be applied to and supported by a variety of payment models.

The table below gives a visual summary of the four pillars of the alternative payment model framework.

Table 30: Alternative Payment Model Framework



Data Source: Health Care Payment Learning and Action Network, Final White paper January 12, 2016

Section C Activities Necessary to Administer and Oversee the EHR Incentive Program

C.1 SMA Verification of Provider Sanction, License, Qualification Status

(SMHP Companion Guide Question C #1)

Verification of Provider Eligibility Status

The SMA will employ both automated and manual processes when performing the Pre-Payment Audit for Sanctions, Licenses and Qualification Status for EPs & EHs to ensure statutory and regulatory requirements are met for the EHR Incentive Program.

Level 1: ePIP performs the 1st level verification during the attestation.

The provider's attestation is checked via a daily cyclic synchronization process against PMMIS. The provider's status and the payee are checked in PMMIS provider database to determine if both are registered as a Medicaid provider, active and in good standing. PMMIS receives and updates provider additions, changes, and deletions from the State's regulatory boards. Unlicensed providers are not qualified or approved to be Medicaid providers and are reflected in PMMIS as inactive and/or not in good standing. Therefore, such providers can be easily identified as ineligible.

Level 2: The EHR Staff performs the 2nd level verification during Pre-Payment Audit process.

Before the EHR incentive payment is authorized by the State, the EHR Staff reviews license, Medicaid enrollment, and sanctions for the Program Year (YYYY) in which the provider is attesting.

- *License:* Provider license is checked against the State's regulatory board.
- *Medicaid Participant:* Provider Medicaid enrollment is checked against PMMIS.
- *Sanctions:* Provider sanctions are checked against the State's regulatory board, HHS OIG Exclusions Database and PMMIS.

C.2 SMA Verification of Provider "Hospital-Based" Status

(SMHP Companion Guide Question C #2)

Verification of Provider "Hospital based" Status

The SMA will employ both automated and manual processes when performing the Pre-Payment Audit for the Medicaid Hospital-Based determination for EPs using Medicaid Patient Volume to ensure statutory and regulatory requirements are met for the EHR Incentive Program.

Medicaid Hospital-Based EPs have 90 percent or more of their covered professional services in a hospital setting. EPs must upload their detail report and enter the total number of Medicaid Title XIX Inpatient Hospital, Emergency Department and Total Patient Encounters paid during the prior calendar year.

Level 1: ePIP performs the 1st level verification during the attestation process.

Provider attestations with results that are 90 percent or more Medicaid Hospital-Based are automatically denied in ePIP and do not require a Level 2 review by the EHR Staff.

Level 2: The EHR Staff performs the 2nd level verification during Pre-Payment Audit process.

The EHR Staff reviews the detail provider report to ensure the data entered in the attestation is correct. Next, the EHR Staff queries Medicaid Title XIX business intelligence data in the Data Warehouse to validate the Medicaid Hospital-Based percentage. If the result shows that the provider has 90 percent or more Medicaid Hospital-Based, then the provider is not eligible.

If applicable, the EHR Staff confirm service delivery location via internal business intelligence reports that are specific to each individual EP. If a large number of the EP's encounters are hospital or Emergency Department based, the EHR Staff confirms the EP's primary practice location. If the EP practices primarily in a hospital and uses his own CEHRT system *(not the hospital's CEHRT system)*, an exclusion is granted for the Hospital-Based criteria.

C.3 SMA Verification of Provider Attestations

(SMHP Companion Guide Question C #3)

The SMA will employ both automated and manual processes when determining program eligibility during the Pre-Payment Audit to ensure statutory and regulatory requirements are met for the EHR Incentive Program.

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EHR Payments System Workflow – Front End (Provider Workflow) and Backend (Support Staff Workflow After Attestation)

Front End Provider Workflow

Level 1: ePIP performs the 1st level verification during the attestation. The provider's attestation is checked via a daily cyclic synchronization process against PMMIS.

Provider attestations with results that do not meet program thresholds are automatically denied in ePIP

The provider must register in ePIP to create an account in order to participate in the Medicaid EHR Incentive Program.

The payee and the provider's active status and provider type are checked via a daily cyclic synchronization process against PMMIS.

For EPs, the Pediatrician indicator is determined based on the provider's specialty in PMMIS. If the Pediatrician's attestation has a minimum 20% but less than 30% patient volume, the payment amount is reduced by one-third of the standard payment amount.

The provider's Electronic Funds Transfer (EFT) status is checked via a daily cyclic synchronization process against AFIS system (new Accounting & Finance Information System in the Division of Business & Finance database).

The provider's attestation documentation must be uploaded in order to complete the attestation.

The provider's reporting periods are checked to ensure the attestation reporting periods meet the requirements. The attestation is not accepted with invalid reporting periods.

The provider's measurements are checked to ensure the provider meets the minimum thresholds. If the provider's attestation does not meet the requirements, the attestation is automatically denied.

The provider's volume measurements are checked to ensure the provider meets the minimum thresholds. If the provider's attestation does not meet the requirements, the attestation is automatically denied.

The payment amount is determined as soon as the provider submits the attestation.

Back End Provider Workflow

The EHR Staff performs the following functions to assist the provider:

- Provider education
- Problem resolution impacting registration, attestation and payment
- Help desk assistance
- Respond to voicemail inquiries
- Respond to email inquiries
- Partner with Arizona Health-e Connection Education and Outreach assistors –formerly Regional Extension Center
- Coordinate with internal units *(DFSM, ISD, OALS, OBI, OIG, etc.)*
- Perform system testing
- Perform Pre-Payment Audit
- Update Workflow Management Tools
- Perform White Paper Analysis
- Identify Fraud, Waste & Abuse

Perform Pre-Payment Audit Validation

Arizona has developed a robust pre-payment validation process that assures provider eligibility and appropriate participation and payment.

Level 2: The EHR Analyst performs the 2nd level verification during the Pre-Payment Audit process which verifies the following criteria:

- *Provider type* - Payee and the provider types are checked against PMMIS.
- *License:* Provider license is checked against the State's regulatory board.
- *Medicaid Participant:* Provider Medicaid enrollment is checked against PMMIS.
- *Sanctions:* Provider sanctions are checked against the State's regulatory board, HHS OIG Exclusions Database and PMMIS.

PA Practice Location - EHR Staff confirms the EP's practice location with the Group and compares it against the FHQC/RHC listing on the State's website. EHR Staff run business intelligence data to confirm if the PA's patient encounter volume demonstrates the EP is the primary provider in the clinic.

FQHC /RHC Practice Location (needy) - FQHC/RHC Practice Location (needy): EHR Staff confirms the EP's practice location with the Group and compares it against the FHQC/RHC listing on the State's website.

EP Practice Location (hospital based) - EP Practice Location (hospital-based): EHR Staff confirms the EP's practice location with the hospital if the EP practices primarily in a hospital and uses his own CEHRT system *(not the hospital's CEHRT system)*,

Group Proxy Patient Volume - EHR Technical SME reviews the practice's aggregate patient volume if the EPs in the group collectively elect to use the group proxy patient volume for the program year to meet the volume criteria.

Individual Patient Volume - EHR Staff reviews the EP's patient volume for the program year.

EH Patient Volume (Acute Care Hospitals) - EHR Staff reviews the EH's patient volume for the program year.

EH Average Length of Patient Stay (Acute Care Hospitals) - The Technical SME reviews the applicable Medicare Cost Report to ensure the ratio of the hospital's Total Inpatient Bed-Days to Total Discharges meets the average length of patient stay criteria (<25 days).

EH Payment Components - The EH payment calculations are programmed in the ePIP system (SLR).

- *During the Pre-Payment Audit*, the Technical SME validates the attestation against the hospital's documentation *(Medicare Cost Reports and Charity Report)* to ensure accuracy of the payment calculation.
- *During the Post Payment Audit*, the SMA Auditor reviews the details that support the Medicare Cost Report and the Charity Report for final reconciliation to the payment calculation.

Certified EHR Technology Documentation – The EHR Staff verifies utilization of certified EHR technology and CEHRT Edition certification requirements are met via review of vendor contract, vendor letters, CMS Certification Number verification against ONC HITECH and CHPL websites.

Perform Pre-Payment Audit Validation

Pre-payment validations for all Stages are completed in alignment with the state's SMHP and the Final Rule, through both system-automated and manual validation processes.

Automated pre-payment verifications include but are not limited to the following:

- Measures are checked to ensure the provider meets the minimum thresholds;
- Reporting period dates are verified;
- CMS EHR Certification ID is valid and appropriate for the program year;
- The appropriate amount of measures are reported
- "Unique patient" measures are checked to ensure the denominators are equal to one another

Manual pre-payment verifications include but are not limited to the following:

- "Segment of patient population" measures are checked to ensure the denominators are less than or equal to the "unique patient" denominators.
- Review of Provider MU Reports compared to the Providers Attestation

(Section C.3 Continued)

Perform Pre-Payment Audit Validation Stage 2 MU

Pre-payment validations for all Stages are completed in alignment with the state's SMHP and the Final Rule, through both system-automated and manual validation processes.

Automated pre-payment verifications include but are not limited to the following:

- Measures are checked to ensure the provider meets the minimum thresholds,
- Reporting period dates are verified,
- CMS EHR Certification ID is valid and appropriate for the program year,
- The appropriate amount of measures are reported,
- "Unique patient" measures are checked to ensure the denominators are equal to one another.

Manual pre-payment verifications include but are not limited to the following:

- "Segment of patient population" measures are checked to ensure the denominators are less than or equal to the "unique patient" denominators.
- Review of Provider MU Reports compared to the Providers Attestation.

Process for Verifying Attestations via the Flexibility Rule

The SMA submitted to CMS on October 30, 2014 Arizona's 2014 Flexibility Rule Changes for the SMHP. Arizona received CMS approval on January 20, 2015 for flexibility and requested and received an extension to its tail period until 8/31/2015.

The SMA revised the SLR to meet the requirements outlined in the Flexibility Rule. The SMA provided onsite training to the REC and Arizona Health-e Connection staff to test the Flexibility programming. The SMA and the REC/AzHeC collaborated on developing a one page brief discussing how flexibility would be administered and developed an updated attestation guide that included the Flexibility option for EPs.

Table 31: Web Based Provider Support Document

Flexibility Rule *The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) released a final rule in August 2014 that grants flexibility for providers who are unable to fully implement 2014 Edition certified electronic health record (EHR) technology (CEHRT) for the 2014 reporting year. Providers may use EHRs that have been certified under the 2011 Edition, 2014 Edition, or a combination of the 2011 and 2014 Editions to submit meaningful data for an EHR reporting period in 2014.* *Only providers who have been unable to fully implement 2014 CEHRT can take advantage of the rule's flexibility options.* *Providers will be required to report using 2014 Edition CEHRT beginning in 2015.* ***CEHRT Flexibility Resources***

To help you understand the final rule's changes to 2014 participation, CMS has developed the following resources. Click the link to learn more.

Educational Resources: CMS has a number of resources to help you participate in the programs.

Final Rule: Regulation that grants flexibility to providers who are unable to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014 due to delays in 2014 Edition CEHRT availability.

CEHRT Flexibility Decision Tool: Providers answer a few questions about their 2014 stage of meaningful use and Edition of EHR certification, and the tool displays the corresponding 2014 options.

2014 CEHRT Flexibility Chart: Chart provides a visual overview of CEHRT participation options for 2014.

2014 CEHRT Rule Quick Guide: Explains the participation options for 2014 based on the Edition of EHR certification providers used during 2014.

***Medicaid EHR Incentive Program Flexibility Resources:** Arizona has developed the following companion resources. Click the links to learn more.*

The CMS 2014 Flexibility Rule is an option available to providers attesting to meaningful use. Vendor documentation is required to support use of the Flexibility Rule.

The CMS 2014 Flexibility Rule does not apply to providers attesting to Adopt, Implement or Upgrade (AIU). Providers attesting to AIU are required to meet the 2014 Edition certification criteria.

Flexibility Chart for Medicaid EPs: High-level overview of the CEHRT options available to providers due to the 2014 CHERT Flexibility Rule. Use in conjunction with the CMS CEHRT Flexibility Decision Tool.

Flexibility EHR Certification Number Guide for Medicaid EPs: High-level overview of the system's EHR Certification Number for the corresponding CEHRT option selected by the provider due to the 2014 CEHRT Flexibility Rule. Use in conjunction with the CMS CEHRT Flexibility Decision Tool.

Click here to link to the CMS CEHRT Flexibility Decision Tool.

Disclaimer: The above tools were created as a service to the public and are not intended to grant rights or impose obligations. The information provided is only intended to be a general summary of the rule's flexibility options. It is not intended to take the place of the regulation.

Figure 19: Flexibility Rule Attestation Workflow

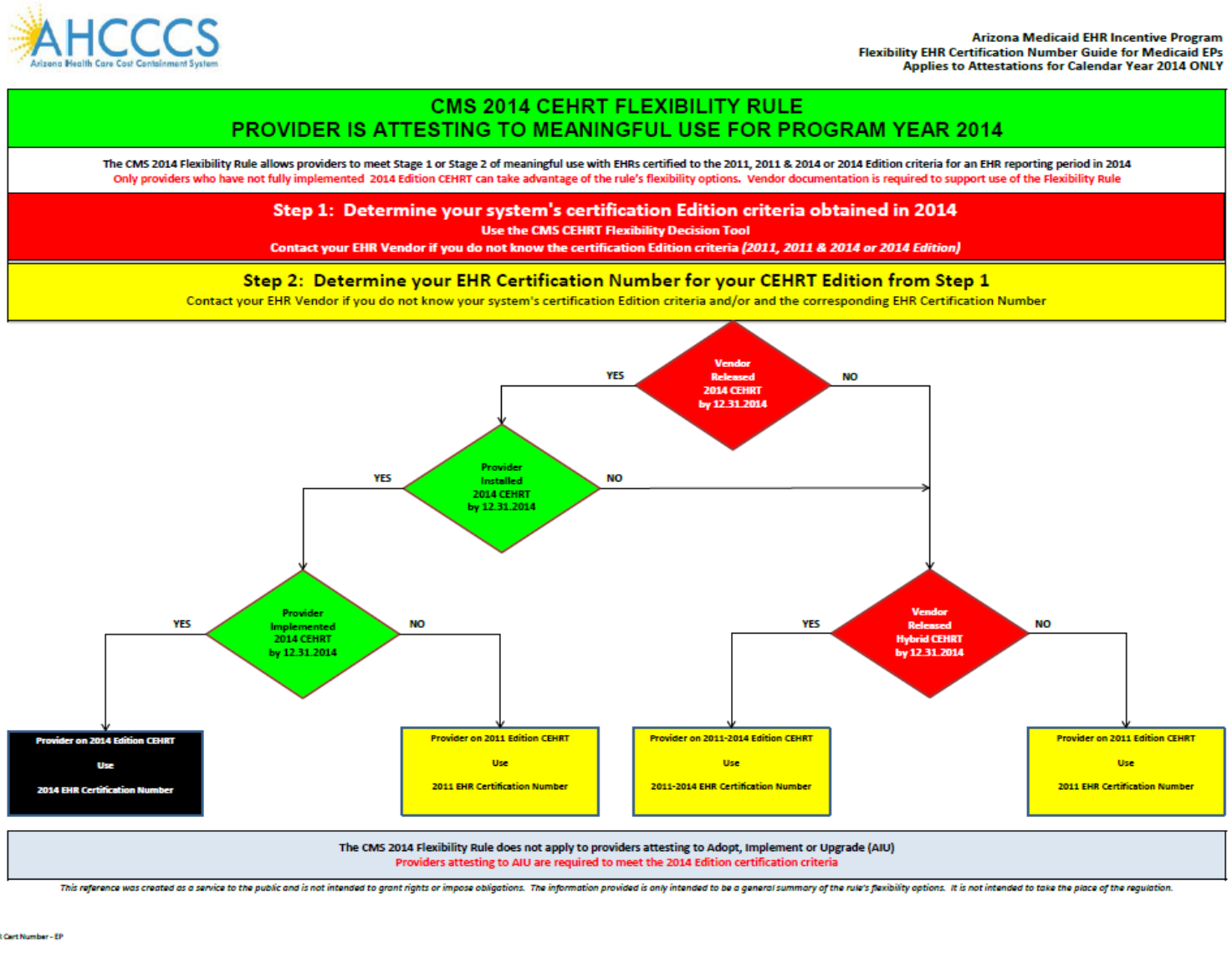

Figure 20: Flexibility Workflow Policy

AHCCCS
Arizona Health Care Cost Containment System

Arizona Medicaid EHR Incentive Program
Flexibility Chart for Medicaid EPs
Applies to Attestations for Calendar Year 2014 ONLY

CMS 2014 CEHRT FLEXIBILITY RULE
PROVIDER IS ATTESTING TO MEANINGFUL USE FOR PROGRAM YEAR 2014

The CMS 2014 Flexibility Rule allows providers to meet Stage 1 or Stage 2 of meaningful use with EHRs certified to the 2011, 2011 & 2014 or 2014 Edition criteria for an EHR reporting period in 2014
Only providers who have not fully implemented 2014 Edition CEHRT can take advantage of the rule's flexibility options. Vendor documentation is required to support use of the Flexibility Rule

Step 1: Determine your system's certification Edition criteria obtained in 2014
Use the CMS CEHRT Flexibility Decision Tool
Contact your EHR Vendor if you do not know the certification Edition criteria *(2011, 2011 & 2014 or 2014 Edition)*

Pre Flexibility Rule Schedule MU Progression	Pre Flexibility Rule Schedule MU Progression	Provider's Certified EHR Technology		
		2011 CEHRT	2011 & 2014 CEHRT	2014 CEHRT
Not Participating in the Program	AIU	Not Eligible Flexibility Rule Not An Option	Not Eligible Flexibility Rule Not An Option	2014 CEHRT Required Flexibility Rule Not An Option
Stage 1 2014 Definition of MU Measures	Stage 1 2013 Definition MU Measures	Flexibility Rule Option Vendor documentation required	Flexibility Rule Option Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
	Stage 1 2014 Definition MU Measures	Not Eligible Flexibility Rule Not An Option	Flexibility Rule Option Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
Stage 2 2014 Definition of MU Measures	Stage 1 2013 Definition MU Measures	Flexibility Rule Option* Vendor documentation required	Flexibility Rule Option* Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
	Stage 2 2014 Definition MU Measures	Not Eligible Flexibility Rule Not An Option	Flexibility Rule Option Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
	Stage 1 2014 Definition MU Measures	Not Eligible Flexibility Rule Not An Option	Flexibility Rule Option* Vendor documentation required	Flexibility Rule Option* Vendor documentation required

** Note that if provider is attesting Stage1 2013 Definition Mu Measures but is in Stage 2, this still counts as Stage 2 for the MU progression.*

The CMS 2014 Flexibility Rule does not apply to providers attesting to Adopt, Implement or Upgrade (AIU)
Providers attesting to AIU are required to meet the 2014 Edition certification criteria

Step 2: Determine your EHR Certification Number for your CEHRT Edition from Step 1
Use the Flexibility Rule EHR Certification Number Guide for Medicaid EPs
Contact your EHR Vendor if you do not know your system's certification Edition criteria and/or and the corresponding EHR Certification Number

This reference was created as a service to the public and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary of the rule's flexibility options. It is not intended to take the place of the regulation.

Flexibility Rule Chart - EP
June 2015

(Section C.3 Continued)

Table 32: Flexibility System Implementation

Below is a chart that summarizes the Flexibility System implementation process.

PRE-SI1– System Implementation						
Review Criteria	**Source**	**System Change**	**Operational Change**	**No Change Necessary**	**Effective Date of Change**	**Comments**
Effective PY 2014: Enable an EP/EH to attest under the Flexibility Rule (using a 2011 or 2011/2014 Combination CEHRT in PY 2014)	495.6	X	X		June 2015	By following our state specific business objective outlined above, all phases of the SDLC were followed and the flexibility rule was implemented.
Effective PY 2014: CMS would permit an extended attestation tail period for PY 2014 to accommodate the Flexibility Rule. Was a longer attestation tail period requested, and, if so, when did the requested tail period end?	495.332	X	X		June 2015	Yes, a longer attestation tail period was approved and the tail period will end on 08/31/2015.

The SMA has developed Flexibility Rule pre and post-audit processes in conjunction with Myers Stauffer for EHs and EPs that participate in the EHR Incentive Program. An updated Audit Strategy was sent to CMS November 30, 2015 with CMS approval received February 16, 2016. Additionally, the SMA utilizes the back-end administrative components of ePIP to easily track which attestation type the EP completed as well as his/her qualifying rationale for needing to attest via Flexibility. A new Audit Strategy is being updated and will be sent to CMS at a later date.

(Section C.3 Continued)

Table 33: Flexibility System Details

PRE-SM2 – SMHP STATE FLEXIBILITY Y/N QUESTIONS				
Ref #	**State Flexibility**	**Yes**	**No**	**Comments (Required)**
PreSM2.1	Did you implement any state policies, laws or regulations for the Medicaid EHR Incentive Program?		No	
PreSM2.2	Subject to §495.332, the state may propose a revised definition of MU of CEHRT, subject to CMS prior approval. Was your state approved by CMS to revise the definition?	Yes		For MU Program Years 2012 and 2013, AHCCCS requested to change the definition of Meaningful Use to exclude Syndromic Surveillance for EPs. As of Program Year 2014, there is not a revised definition in place for MU.
PreSM2.3	Do you have any plans to require providers to submit clinical quality measures (CQMs) electronically?	Yes		TBD pending functionality at The Network and input from Health Plans
PreSM2.4	Will system changes be required to be implemented due to the IRS ruling on 1099s to providers?	Yes		Changed from payee to designee for 2013 – present
PreSM2.5	Do you have an approved HIE IAPD?	Yes		Approved March 12, 2015 HITECH v 5.1
PreSM2.6	Does your state have a statewide HIE?	Yes		Yes, Arizona Health-e Connection operates and manages the network (HINAz)
PreSM2.7	Does your state have a Medicaid-only HIE?		No	Medicaid Health Plans and Regional Behavioral health Authorities must join the network per contract
PreSM2.8	Does your state utilize a Children's Health Insurance Program (CHIP) proxy? If so, please describe the methodology.		No	N/A

PreSM2.9	Does your state utilize a proxy for anything else (Qualified Medicare Beneficiaries, Managed Care)? If so, please describe your methodology.		No	N/A
PreSM2.10	Does your state assist in providing numerator data for EPs or EHs? If so, please describe your methodology.		No	Providers are expected to produce their own data, which is reconciled against the agency encounter data under pre-payment review. Providers can request data from the Agency; however, they must go through a formal process (outside of the EHR realm) and pay for the data, charged by the development hour.

(Section C.3 Continued)

Table 34: Flexibility System Details

PRE-SM3– STATE FLEXIBILITY TIMEFRAME QUESTIONS		
Ref #	**Timeframe**	**Date**
PreSM3.1	What is your timeframe for having Stage 2 MU system changes implemented?	Stage 2 system changes (prior to flexibility) were implemented in October 2014. With the introduction of Flexibility, extensive system accommodations were needed to effectively implement and manage the Rule changes. Stage 2 Flexibility options were implemented in June 2015.
PreSM3.2	What is your attestation tail period?	The Flexibility tail period is through August 31, 2015.
PreSM3.3	What is your frequency for EHR Incentive payments?	EHR Incentive payments are made one time a month. Payments are issued within 45 days of approved attestation payment determinations.

Table 35: Flexibility System Details

PRE-SM4 – STATE FLEXIBILITY QUESTIONS CONTINUED		
Ref #	**Flexibility**	**Explanation**
PreSM4.1	How do you handle non-enrolled providers?	In order to participate in the program, providers must be an active Medicaid provider. Non-enrolled providers are required to register with the AHCCCS Administration under the management of the Office of Inspector General *(Provider Registration).*
PreSM4.2	Will CMS be conducting your EH post payment audits?	Yes, Arizona elected to have CMS conduct the MU post payment audits and appeals for dually eligible hospitals participating in the EHR Incentive Program.
PreSM4.3	Describe your public health integration efforts (i.e., Immunization Registry, Other Registries, Syndromic Surveillance).	Just beginning with new functionality at The Network (Mirth) PH Portal
PreSM4.4	Describe any efforts in your state to ensure providers return for 2nd year and beyond payments.	Education and Outreach contract with former REC to help move providers through the MU continuum. Focus year 1 = Registration & AIU, Year 2 MU1 – MU2 Arizona is working with Myers and Stauffer to improve and increase provider outreach and education.
PreSM4.5	What is your state's definition of a group practice?	The lawful or legally standing business entity with legal capacity to operate as a Group Practice and with accountability for all business activity. The administration of the Arizona Medicaid EHR Incentive Program captures a single business entity linked by any or all of the following criteria: • Single and/or multiple Employer Identification Number(s) (TIN). • Single and/or multiple National Provider Identifier (NPI) • Single and/or multiple Group AHCCCS Provider Numbers *(defined by AHCCCS Administration under the management of the Office of Inspector General (Provider Registration).* All sources of information are used to verify all providers associated to the Group Practice's single business entity.
PreSM4.6	What is your state's definition of a Pediatrician?	A pediatrician is medical doctor who manages the physical, behavioral, and mental health of children from birth until age 21. As such, Pediatricians must be an AHCCCS Provider who meets the physician scope of practice rules, hold a Doctor of Medicine or Doctor of Osteopathy degree, and hold a current license and board certified in Pediatrics.

Perform Pre-Payment Audit Validation Stage 3

Stage 3 MU has been finalized in Rule; Arizona is in the process of building an electronic attestation system that meets all Program requirements. Once attestations begin for Stage 3, EHR Program staff will conduct pre-payment validations in the same manner as other Stages, ensuring that appropriate automated and manual checks are in place for effective review.

Conduct Program Analysis and Measurement

Ongoing analytics are an integral part of the EHR Incentive Program. Data is reviewed at least weekly to ensure that workload is on track. There are various subsets of data that the team relies on, ranging from registration data to attestation trends. Program analytics support everything from attestation payment determinations and audit selections to provider outreach efforts and future planning. Program analysis are provided monthly to the managers and then quarterly to the HIT Steering Committee and CMS, and also annually to stakeholders and CMS.

EH Participation Verification

The following hospitals are eligible to participate in the Medicaid EHR Incentive Program: Acute care hospitals (including CAHs and cancer hospitals) with at least 10 percent Medicaid patient volume; and Children's hospitals excluded from Medicaid patient volume requirements). The Children's Hospitals must demonstrate meaningful use with the SMA.

Under the Medicaid EHR Incentive Program, EHs can qualify for incentive payments if they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology during the first participation year or successfully demonstrate meaningful use of certified EHR technology in subsequent participation years. Data from CMS sent to the SMA via a C5 file transition is used as the primary determination for Meaningful Use, while the SMA completes the eligibility determination for all other components.

C.4 SMA Communication with Providers Regarding Eligibility, Payment Etc.

(SMHP Companion Guide Question C #4)

Communication with EPs Regarding Eligibility and Payment

The EHR Staff communicates with providers via the EHR Email box at: EHRIncentivePayments@azahcccs.gov or EHR Help Desk at 602.417.3333. A provider can also check the status of their attestation and payment by logging onto their ePIP accounts.

If the provider's attestation data does not meet the program requirements, a message is displayed on the Attestation Status page. If the provider does not meet the MU requirements, the measures results are displayed on the MU Report Summary page.

Plans for Stakeholder Engagement about MU Stage and Other Changes

AHCCCS operates a website for all EPs participating in the EHR program which contains a provider attestation portal called ePIP and houses reference and resource information including news and alerts which are put out routinely by the agency. The SMA and AzHeC maintain two different listserv that providers can sign up for to receive timely notices and alerts about changes in the program or upcoming deadlines. AzHeC publishes a newsletter which contained important program changes and updates and is sent to their listserv of over 3,200 participants.

Based on results of the AHCCCS EP online survey project, more providers wanted faster communication and resolution to their attestation questions or problems. Based on these findings, the agency is looking to automate some functions so that providers can be notified more quickly if there are issues with their attestation. The agency is planning to hire temporary workers to assist with customer service responses.

For the purposes of recruiting providers to the EHR Incentive Program and assisting participating providers in progressing through the stages of Meaningful Use, AHCCCS has contracted with the Arizona Health-e Connection to perform education and outreach to eligible professionals. Through their website, webinars, phone calls and newsletters, providers are being educated about the MU program changes.

C.5 SMA Methodology for Patient Volume Calculation

(SMHP Companion Guide Question C #5)

Patient Volume Calculation Methodology

EPs and EHs *(excluding Children's Hospitals)* are required to meet a specific patient volume threshold each program year in which they are applying to be eligible for an EHR incentive payment. Arizona has chosen to adopt the Patient Encounter methodology.

The qualifying patient volume thresholds for the Medicaid EHR Incentive Program are given in the following table:

Table 36: EHR Patient Volume Threshold Criteria

Entity	Minimum 90-day Medicaid Patient Volume Threshold	
Physicians	30%	Or the Medicaid EP practices predominantly in an FQHC or RHC – 30% needy individual patient volume threshold
Pediatricians	30% or optional 20%	
Dentists	30%	
Certified nurse Midwives	30%	
Physician Assistants when practicing at an FQRC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	
Acute care hospital	10%	
Children's hospital	N/A	

Eligible Professionals

Stage 2 Regulation
Effective January 1, 2013, Medicaid Patient Encounters include services rendered on any one day to a Medicaid Title XIX enrolled individual, regardless of payment.

Stage 1 Regulation
Prior to January 1, 2013, Medicaid Patient Encounters are services rendered to an individual on any one day where Medicaid Title XIX paid for part or all of the service, individual's premiums, copayments and/or cost-sharing.

Counting Patient Encounters
Patient Encounters are measured by counting unique visits based on date of service per provider per patient. Multiple claims for the same patient on the same day are counted as one visit for each rendering provider.

Patient Volume Calculation for EPs
The Patient Volume Threshold percentage is defined as the total Medicaid (or Needy) Patient Encounters in any representative continuous 90-day period in the preceding year, divided by the total of all patient encounters in the same 90-day period multiplied by 100. The option to allow the selection of a reporting period that is 12 months prior to attestation is not available for Arizona.

Patient Volume Types
EP measurements are based on the Medicaid Patient Volume or Needy Patient Volume Type.

Medicaid Patient Encounters (numerator) - Medicaid Title XIX patient encounters only.

Needy Patient Encounters (numerator) - Medicaid Title XIX, CHIP Title XXI & sliding scale/uncompensated patient encounters. Only EPs in FQHCs/RHCs have a special option of qualifying using either the Medicaid Patient Volume or Needy Patient Volume Type.

Pediatricians
Pediatricians have a special exception in meeting the patient volume. If the Pediatrician's attestation has a minimum 20% but less than 30% patient volume, the payment amount is reduced by one-third of the standard payment amount.

Group Practice Definition
For the purposes of determining the Practice's Aggregate Patient Volume (Group Proxy) for the Arizona Medicaid EHR Incentive Program, a Group is defined as:

The lawful or legally standing business entity with legal capacity to operate as a Group Practice and with accountability for all business activity. The administration of the Arizona Medicaid EHR Incentive Program captures a single business entity linked by any or all of the following criteria:

- Single and/or multiple Employer Identification Number (TIN).

- Single and/or multiple National Provider Identifier (NPI)
- Single and/or multiple Group AHCCCS Provider Numbers (defined by AHCCCS Provider Registration)

All sources of information are used to verify all providers associated to the Group Practice single business entity.

Eligible Hospitals

Stage 2 Regulation
Effective Federal Fiscal Year 2013, Medicaid Patient Encounters are services rendered to a Medicaid Title XIX enrolled individual, regardless of payment measured by:

- Inpatient hospital discharges
- Emergency department discharge. An emergency department must be part of the hospital under the qualifying CCN.

Stage 1 Regulation
Prior to Federal Fiscal Year 2013, Medicaid Encounters are services rendered to an individual where Medicaid paid for part or all of the service, individual's premiums, co-payments, and/or cost-sharing measured by:

- Inpatient hospital discharges
- Emergency department discharge. An emergency department must be part of the hospital under the qualifying CCN.

Counting Patient Encounters
EH Patient Encounters are measured by counting unique hospital facility patient discharges for the same patient on the same day from the inpatient hospital or emergency department.

Patient Volume Calculation for Acute Care Hospitals
The Patient Volume percentage is defined as the total Medicaid patient encounters in any representative continuous 90-day period in the preceding year Federal Fiscal Year (FFY), divided by the total of all patient encounters in the same 90-day period multiplied by 100.

C.6 SMA Verification of EP and Acute EH Patient Volumes

(SMHP Companion Guide Question C #6)

The SMA will employ both automated and manual processes when performing the Pre-Payment Audit for the patient volume determination to ensure statutory and regulatory requirements are met for the EHR Incentive Program.

Level 1: ePIP performs the 1st level verification during the attestation process.

Provider attestations with results that are below the patient volume requirements are automatically denied in ePIP and do not require a Level 2 review by the EHR Staff. The attestation is not accepted with invalid reporting periods.

Level 2: The EHR Staff performs the 2nd level verification during Pre-Payment Audit process.

The EHR Staff:

- Reviews the detail provider report to ensure the data entered in the attestation is correct
- Prepares a white paper analysis of the Numerator and Denominator.
- Queries Medicaid Title XIX and CHIP Title XIX business intelligence data in the Data Warehouse to validate the Medicaid Title XIX and CHIP Title XIX (for Needy Patient Encounters).

If the projection result shows that the provider does not meet the volume requirements, then the provider is not eligible.

C.7 SMA Verification of EP s at FQHCs/RHCs meet the "Practice Predominantly" Requirement

(SMHP Companion Guide Question C #7)

Verification of "Practices Predominantly" Status

The SMA will employ both automated and manual processes when performing the Pre-Payment Audit for the Practice Predominantly determination for EPs using Needy Patient Volume to ensure statutory and regulatory requirements are met for the EHR Incentive Program.

Practicing Predominantly EPs have over 50 percent of his/her patient encounters over a period of six (6) months in the prior calendar year occur at FQHC/RHC facilities.

Level 1: ePIP performs the 1st level verification during the attestation process.

Provider attestations with results that are less than 50 percent Practice Predominantly are automatically denied in ePIP and do not require a Level 2 review by the EHR Staff.

Level 2: The EHR Staff performs the 2nd level verification during Pre-Payment Audit process.

The EHR Staff reviews the detail provider report to ensure the data entered in the attestation is correct. Next, the EHR Staff queries Medicaid Title XIX (and if applicable CHIP Title XXI) business intelligence data in the Data Warehouse to validate reasonability of the Practice Predominantly percentage. If the result shows that the provider has less than 50 percent FQHC/RHC encounters, then the provider is not eligible.

The EHR Staff confirms service delivery location via internal business intelligence reports that are specific to each individual EP. Only patient encounters for FQHC/RHC can be used in the numerator.

C.8 SMA Verification of Adopt, Implement, Upgrade of CEHRT

(SMHP Companion Guide Question C #8)

Verification of AIU of CEHRT

The SMA will employ both automated and manual processes when performing the Pre-Payment Audit for EHR Technology documentation for EPs attesting to Adopt, Implement, Upgrade (AIU) of certified EHR Technology to ensure statutory and regulatory requirements are met for the EHR Incentive Program.

Level 1: ePIP performs the 1st level verification during the attestation process.

Provider attestations with an invalid EHR Certification Number result are automatically denied in ePIP. The SLR (ePIP) links to the ONC CHPL site to ensure that the EHR Certification Number being reported by the provider is for a valid, certified system.

Level 2: The EHR Staff performs the 2nd level verification during Pre-Payment Audit process.

The EHR Staff:

- Reviews the EHR vendor documentation including but not limited to vendor contracts, purchase orders and billing invoices.
- Reviews the vendor documentation that demonstrates the CEHRT Edition certification requirements
- Validates the vendor name for the EHR Certification Number

If the result shows that the provider's EHR system did not meet the program requirements (*executed contract, appropriate CEHRT Edition certification requirements, etc.*) by December 31st of the Program Year in which the provider is applying, then the provider is not eligible.

C.9 SMA Verification of CEHRT for Second Year Meaningful Use

(SMHP Companion Guide Question C #9)

Verification of CEHRT for Subsequent Years of MU

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The SMA will employ both automated and manual processes when performing the Pre-Payment Audit for EHR Technology documentation for EPs attesting to meaningful use of certified EHR Technology to ensure statutory and regulatory requirements are met for the EHR Incentive Program.

Level 1: ePIP (automated) performs the 1st level verification during the attestation process.

Provider attestations with an invalid EHR Certification Number result are automatically denied in ePIP. The SLR (ePIP) links to the ONC CHPL site to ensure that the EHR Certification Number being reported by the provider is for a valid, certified system.

Level 2: The EHR Staff (manual) performs the 2nd level verification during Pre-Payment Audit process.

The EHR Staff:
Reviews the EHR vendor documentation including but not limited to vendor contracts, purchase orders, billing invoices, screen shots of system version, etc.
Reviews the vendor documentation that demonstrates the CEHRT Edition certification requirements
Validates the vendor name for the EHR Certification Number
Reviews year-to-year consistency for EP vendors. If the provider switches vendor, they must provide updated supporting documentation for the new EHR vendor contract.
Reviews MU & CQM Reports to ensure the data entered in the MU portion of the attestation is correct.
If the result shows that the provider's EHR system did not meet the program requirements *(executed contract, appropriate CEHRT Edition certification requirements, correct MU & CQM Reports, etc.*) by December 31st of the Program Year in which the provider is applying, then the provider is not eligible.

C.10 SMA Proposal of Permissible Changes for Meaningful Use

(SMHP Companion Guide Question C #10)

Arizona does not have any stage changes to the MU definition, as permissible per the Final Rule. Arizona has instituted extensions to its program year tail periods:

- Program Year 2015 Attestation Tail Period – Extension Request

Eligible Professionals

Program Year 2015 - Typically, Arizona has implemented a three-month tail period for EP attestation completions following the year of the Program Year. However, due to

the timing of the revised Rule and necessary system updates, Arizona requested a Program Year 2015 tail period extension through August 1, 2016.

Eligible Hospitals

Program Year 2015 - Typically, Arizona has implemented a three-month tail period for attestation completions following the year of the Program Year. However, due to the timing of the revised Rule, the change from Federal Fiscal Year to calendar year (for reporting purposes) and necessary system updates, Arizona requested permission to extend its tail period for Eligible Hospitals wishing to attest to Program Year 2015 in April, 2016. CMS reviewed the request and granted the extension in July, 2016. Under that request the tail period was extended to September 30, 2016.

A new request was sent to CMS in September 21, 2016 requesting another tail period extension for hospitals that want to attest for Program Year 2015. AHCCCS requested the extension because there were a number of hospitals that were in their Year 3 and Year 4 program years and could not be paid until the outcome of the states HHS-OIG EHR Incentive Program audit.

AHCCCS requests additional flexibility to extend its program year 2015 payment pending outcome of the HHS OIG EH audits. We requested an additional extension to March 31, 2017 assuming issues are resolved between the SMA and CMS is requesting a Program Year 2015 and received approval on October 17, 2016.

C.11 SMA Verification of Providers' Use of CEHRT

(SMHP Companion Guide Question C #11)

SMA Process for Providers Use of CEHRT

See sections C.8 and C.9 above.

As part of the EHR Incentive Program, as the functionality of the HIE increases, the SMA expects to require more information from the MCOs and their provider networks electronically versus through onsite or paper chart audits.

The SMA is planning to increase the number of measures and types of SMA reporting to be electronic versus through claims/encounters or through paper reporting. Currently, the SMA has established an e-prescribing reporting requirement for the MCOs and the providers that are in their network. The agency is starting to work with the HIE to plan for the electronic clinical quality measure submission and is working with the Network to support MU Public Health reporting for immunizations, labs, syndromic surveillance, cancer registry and a specialized registry.

The agency completed its MITA Self-Assessment which has informed our Health IT Plan. The assessment found that most of the agency's processes were at a level two and over the course of the next five years as CMS establishes more standards; the agency expects to move higher in the MITA framework.

C.12 SMA Collection of MU and ECQM Data

(SMHP Companion Guide Question C #12)

CQM Initiatives Evolving from Meaningful Use

With regards to the Clinical Quality Measures (CQMs) associated with Meaningful Use, AHCCCS is continually looking for opportunities to utilize specific fields in provider EHRs to collect data for CQMs and Meaningful Use objectives, as well as the Children, Adult and Maternity Core Measures, many of which align with Meaningful Use measures. It is anticipated that most, if not all, data necessary to conduct these and other outcomes measures will be available electronically from providers that have implemented EHRs.

In addition, AHCCCS continues to explore possible use of the state's HIE to collect more detailed information from EHRs in order to provide Medicaid data necessary for the Agency to calculate, report and/or develop QI initiatives related to Meaningful Use. AHCCCS anticipates storing necessary field data in the AHCCCS data warehouse for use in analyzing and reporting CQMs and developing interventions to improve care. The EHR data will also be used to supplement current HEDIS outcomes measures and mandatory Performance Improvement Projects as required by federal Medicaid Managed Care regulations (42 CFR 438.240). AHCCCS will have different approaches to clinical outcome measures for the short-term and the long-term.

Short Term Approach for Meeting Meaningful Use

In order to meet federal requirements and expectations for health care quality improvement, AHCCCS will capture timely, accurate and meaningful data that can be used to monitor quality among various types of providers and in a way that is consistent with national standards or core measures developed/adopted by CMS, so that health information is available and actionable from both the individual provider level and also from a system perspective. To move further down this path, AHCCCS has implemented sections of the American Recovery and Reinvestment Act (ARRA) to promote and provide Medicaid EHR Incentive Program payments for the adoption and Meaningful Use of EHRs to EPs and EHs, as well as those related to the electronic use and exchange of health information for quality improvement and oversight purposes.

Agency staff has implemented Meaningful Use functionality and reporting of the related CQMs by EPs through the ePIP system. AHCCCS staff is also responsible for collecting, analyzing and reporting existing clinical quality measures and other quality and outcomes data utilized by the Agency has plans to develop processes for collection, storage, analysis and reporting of MU/CQM data from EPs and potentially EHs. AHCCCS' EHR staff are evaluating existing processes for collection, analysis and reporting of clinical quality data, including Healthcare Effectiveness and Data Information Set (HEDIS) measures currently collected, to determine how the Agency may use existing processes/resources and what additional resources or tools are necessary to fulfill federal requirements. The Agency has identified staff that will be responsible for monitoring and evaluating quality measurement and improvement.

Processes under development include methods of data validation that are the most cost/resource efficient, and mechanisms for reporting aggregate data by provider to CMS. Existing HEDIS and other reports may be used to benchmark provider-reported data and

identify any opportunities for quality improvement in the future. Data imported from public health registries such as the Arizona State Immunization and Information System (ASIIS) also may be used to benchmark and/or validate provider-reported data in the future.

Long Term Approach for Meeting Meaningful Use

Long-term, AHCCCS will expand capabilities to the next level of inter-operability as we head into a new generation of quality reporting. Through the wide-spread implementation of EHRs, AHCCCS anticipates improvements in monitoring of quality of care and outcomes at a variety of levels in the Medicaid system: provider, managed care organization, county/geographic service area, population (e.g., by race/ethnicity, diagnosis or special health care need), program/state and including national comparisons.

It is anticipated that Agency and MCO administrative burden will decrease as AHCCCS moves towards receiving data from the state HIE.

C.13 Data Collection Alignment with Other CQM Data

(SMHP Companion Guide Question C #13)

MU Data Alignment with Other CQM Data

To further expand the focus on clinical outcomes rather than processes or episodes of care, AHCCCS will focus on developing the mechanisms needed to incorporate electronic health information into quality performance measures, such as the HEDIS Measures and Meaningful Use measures. EHRs offer a much richer data source than administrative data, providing information such as laboratory values indicating improvement in a members' health status or condition, and whether comprehensive preventive and follow-up services were provided during a visit, such as those required under the federal Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) Program. Implementing a philosophical shift toward incorporating EHR connectivity/data sources will add another layer of complexity to the clinical outcomes measure process.

AHCCCS anticipates the following objectives related to capturing and sharing data:

- Support reporting of CMS Core Measures and Meaningful Use and CQMs as they are approved and implemented by CMS, including reporting of HEDIS measures.
- Determine ways to improve quality oversight of contracted managed care organizations and their network providers, including ensuring complete, accurate, and timely reporting of data.
- Secure electronic health information from Medicaid providers including hospitals, physicians, FQHCs, RHCs, behavioral health providers, long- term care facilities, dental providers, etc., in order to test processes and applications for quality monitoring and oversight.
- Develop mechanisms to reduce process waste and maximize automation to increase administrative simplicity and efficiency in quality measurement/oversight.

(Section C.13 Continued)

- Share information for care coordination and quality measurement with other entities serving AHCCCS members (e.g., Arizona Department of Health Services, Tribal Entities, IHS) in a timely and seamless manner while ensuring the privacy of AHCCCS members and data security.
- Enhance existing processes to report quality measurement data through the AHCCCS website, as well as through stakeholder forums (State Medicaid Advisory Committee, Arizona Medical Association Maternal and Child Health Committee, The Arizona Partnership for Immunization, legislative caucuses, etc.).
- Increase transparency in the Medicaid program by making available performance and quality data to a variety of stakeholders, including members/patients, other health care professionals, policy makers and the public at large.

AHCCCS also anticipates that activities implemented as a result of clinical outcomes and Meaningful Use measures may result in improved outcomes. The use of EHRs and the implementation of clinical outcomes measures may result in an increase in productive patient/provider interactions, improved clinical decision support, improved delivery system design including patient navigator, work up nurses, care manager/clinical outreach coordinator, health educator and support staff, and the establishment of EP and EH goals such as, better chronic disease control, reduced medication errors, improved discharge planning, improved patient cycle time, improved patient self- management, reduced tobacco use, improved immunization rates and reduced inappropriate ER utilization.

AHCCCS also expects the reporting of CQMs to result in changes to the organizational and payment structures surrounding the care experience to focus on outcomes and quality of life. Current changes underway include payment reform methodologies based on performance of established measures as well as contractor promotion of patient-centered medical home and accountable care organization models of care. Ultimately, focusing efforts on clinical outcomes measures may result in cost savings/benefits for AHCCCS including:

- Increased chart data from EHRs will increase accuracy and completeness of data used to report clinical quality measures (including HEDIS) without the cost of data abstraction by nurses or other qualified individuals
- AHCCCS data will be more comparable to other states when submitted to CMS and NCQA
- Complements current data sources by including chart data, public health data, registry data into all applicable clinical quality measures without additional human resource requirements
- Reduced administrative burden on providers, health plans and AHCCCS as data can be collected, received and analyzed electronically

(Section C.13 Continued)

- Identification of opportunities for population health management and quality improvement initiatives
- Potential to reduce clinical and medication errors
- Potential to drive down emergency room and inpatient utilization
- Potential to improve discharge planning and thus reduce hospital re-admissions

AHCCCS will eventually use Meaningful Use-reported data as a comparison to other performance measures tracked by the Agency. In addition, AHCCCS continues to monitor the development of new Meaningful Use measures, especially those proposed for Stage 3, to determine alignment of Meaningful Use measures to agency-selected performance measures. As noted, many of the CHIPRA and Adult Core Measures, as well as existing clinical quality/performance measures utilized by AHCCCS to evaluate contractor performance and the program overall, align with Meaningful Use CQMs. Since AHCCCS already has the capability to analyze existing quality measures by Contractor, county/geographic service area (GSA), etc., data collected from providers will be compared to other measure data collected and reported by AHCCCS to check for reasonableness and to identify opportunities for improvement; e.g., by provider type or GSA. The EHR data will also be used to supplement current HEDIS outcomes measures and Performance Improvement Projects as required by federal Medicaid Managed Care regulations (42 CFR 438.240), since EHRs have the capability to produce additional information for quality improvement that cannot be obtained from administrative (encounter) data alone.

C.14: IT, Fiscal and Communication Systems That Will Support Implementation of the EHR Incentive Program

(SMHP Companion Guide Question C #14)

IT and Fiscal Systems Supporting the EHR Incentive Program

Information Systems: The EHR Incentive Program has long-established systems (such as the Electronic Provider Incentive Payment system, also known as ePIP, and all other systems such as PMMIS, Data Warehouse, Outlook, Oracle, and AFIS - described below) in place to support all aspects of attestation, review, payment, audit, and ongoing provider support. There are no planned changes to the systems beyond those that are needed to maintain operations of the Program or support federal Rule changes.

In order to achieve the goals and objectives of the EHR Incentive Program, AHCCCS adopted and established the appropriate technical infrastructure to support key initiatives and activities. The following systems were utilized:

- PMMIS subsystems, including:
    - Provider: To validate provider Medicaid status, type of service, NPI, TIN, and EFT status

  - Finance and Payments: To process the actual incentive payments
  - Data Warehouse: To capture the Medicaid EHR Incentive Program data, report provider patient volume, and generate program reports

- Microsoft Outlook email for communication with providers as they register and progress through the process to payment

The ePIP was built for provider registration, attestation, and payment. The ePIP system interfaces with the R&A system at CMS and PMMIS. AHCCCS will use PMMIS as a source for current provider information. The website accesses PMMIS using a script to call provider information. No modifications to PMMIS have been needed given AHCCCS has modified the system to comply with the new HIPAA standards, 5010, and implemented ICD-10 in October 2015. APDs are already approved for these projects. However, the ePIP continues to be updated according to the new rules for Stage 1 Meaningful Use, Stage 2 Meaningful Use, Stage 3 Meaningful Use, and will continue to change as new rules are published in the future.

The process AHCCCS will use to assure that all Federal funding, both for the 100% incentive payments as well as the 90% Administrative match are accounted for separately and not commingled with the MMIS FFP is that at this time the agency has not requested any MMIS funds for the HITECH program. All EHR program activity is tracked separately from other agency activities and is reported on the CMS 64 on its own line items.

Fiscal - The process AHCCCS will use to assure that payments go to an entity promoting the adoption of certified EHR technology and are designated by the state if participation in the arrangement is voluntary and is no more than 5% of payments are retained for cost unrelated to EHR technology adoption. This is not applicable to AHCCCS. AHCCCS did not delegate the promotion to any entity for the adoption of the certified EHR technology or handling of any incentive payments to an external entity.

Additionally, AHCCCS ensures that no EHR incentive payments go through the MCO capitation process because the incentive payments are being paid by the agency to the individual eligible professional and eligible hospital or as assigned. No funds are paid by the agency to MCOs for the EHR program.

The table below shows the major milestones of the Arizona Medicaid EHR Incentive Program.

Table 37: AHCCCS Major IT Milestones

AHCCCS IT Major Milestones Activity	Completion Dates
Implement AIU – Eligible Hospitals	8/12/2011
Implement AIU - Eligible Professionals	1/05/2012
Implement MU Stage 1 Phase 1	10/29/2012

AHCCCS IT Major Milestones	
Activity	Completion Dates
Implement MU Stage 1 Phase 2	2/15/2013
Implement MU Stage 1 Phase 3	7/31/2014
Implement Stage 2	9/1/2014
Implement Flexibility	6/22/2015
Implement 2015 MU	5/19/2016
Implement 2016 MU (First Year MU Providers)	8/10/2016
Implement 2016 MU (All Remaining Providers)	1/03/2017
Implement Stage 3 MU (Projected)	4/1/2017

Data Source: AHCCCS ISD, November 2016

Additionally, AHCCCS has implemented a process to account for all Federal funding. AHCCCS is required to follow the State Accounting Manual guidelines for recording accounting transactions. By policy, Federal Grants are recorded in the Federal Grants Fund. Separate tracking is maintained by unique grant and phase numbers in the State's accounting system (AFIS). The unique grant and phase numbers provide a separate account for each federal grant. By state statute, normal and APD/PAPD enhanced MMIS funds are accounted for in the AHCCCS Fund that is separate from the Federal Grants Fund and that will prevent any commingling of the HIT grant funds.

In addition, to ensure that funding is being properly allocated by providers, the ePIP system that includes a statement that requires the provider to verify that they are voluntarily applying for this payment and that no more than five percent of such payment is retained for costs unrelated to EHR technology adoption. The provider signs an attestation to this fact. Additionally, AHCCCS ensures that no EHR reimbursement funds go through MCO capitation process given that the funds are being paid by the Agency and not through the MCO. Arizona EHR incentive payments are not payable to MCOs.

To prevent fraud from inappropriate access to the provider's ePIP account, the EHR Staff also emails a payment verification/notification to the provider of intent to auto-assign the EHR incentive payment.

For Communicating with Providers

The SMA has a dedicated email, phone, listserv and website for provider inquires and information. Providers can access the general program information at the Arizona website and contact the EHR Staff at:

- Email EHRIncentivePayments@azahcccs.gov

- EHR Help Desk 602-417-4333
- Website: http://www.azahcccs.gov/EHR/default.aspx
- Listserv: http://listserv.azahcccs.gov/cgi-bin/wa.exe?HOME

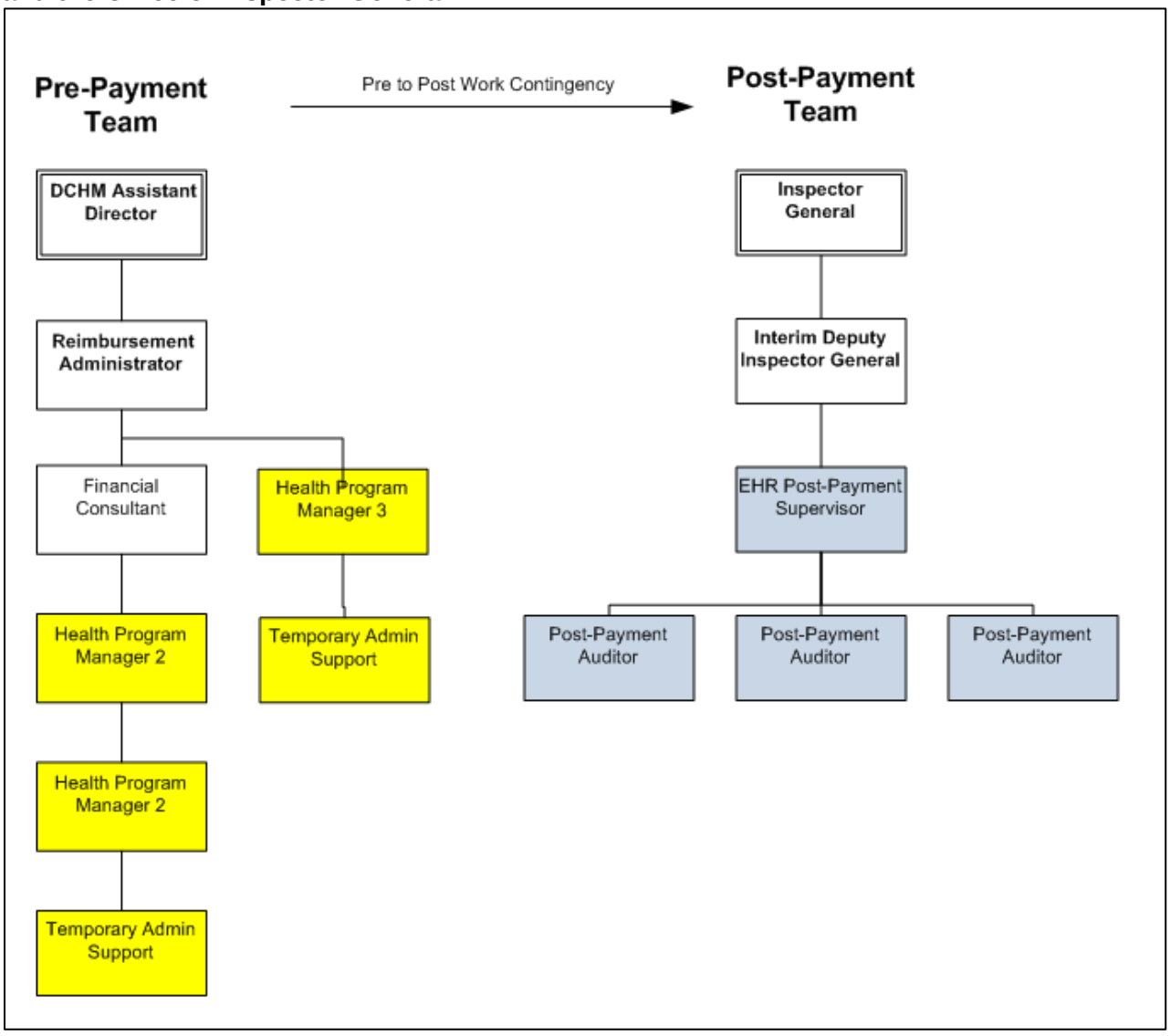
The SLR (ePIP) also displays basic messages regarding attestation and payment.

The provider can check the status of their attestation and payment by logging onto their ePIP accounts. If the provider's attestation data does not meet the program requirements, a message is displayed on the Attestation Status page. If the provider does not meet the MU requirements, the measures results are displayed on the MU Summary page.

Updated Organizational Chart: As of October 1, 2016, the EHR Incentive Program staff has different reporting relationships. The pre payment team is currently still in the Division of Health Care Management but reporting up through the Reimbursement Administrator.

The Post Payment team has been moved to the SMA Office of Inspector General in order to ensure there is a good firewall between the prepayment team and the post payment team. Please see the updated organizational chart below.

Figure 21: EHR Team Organizational Chart in the Division of Health Care Management and the Office of Inspector General



Data Source: DHCM and OIG, October, 2016

C.15 SMA IT System Changes Needed to Implement the EHR Incentive Program

(SMHP Companion Guide Question C #15)

SMA IT System Changes Needed to Implement the EHR Incentive Program

The SMA maintains an in-house developed system that addresses the needs of the EHR Incentive Program. This system (ePIP) currently includes registration, attestation, and account

management functionality for eligible professionals and eligible hospitals as well as an internal administrative portal for the EHR staff to utilize for payment decisions, group/provider management, and auditing purposes.

Program Year 2016 is open now for MU 1st Year and AIU, there are some minor changes that will go in by New Year's 2017. All EPs will be eligible for a 90 day reporting period starting 1/1/2017. Previously MU 2nd year through their final year required a 12 month reporting period.

Ongoing meetings are underway to document all necessary changes; a formal plan for implementation of the new Rule will be submitted in January in accordance with CMS direction.

C.16 SMA Timeframe for Systems Modifications

(SMHP Companion Guide Question C #16)

SMA Timeframe for Pending System Changes

The SMA opened Program Year 2015 Meaningful Use in May, 2016. Ongoing work from May focused on the changes for Program Years 2016. MU 2016 was implemented in August, 2016 for first year providers. The remaining providers can begin attestation for MU 2016 in January, 2017.

Stage 3 is optional for Program Year 2017 and required in Program Year 2018. CMS has not yet published full requirements for Program Year 2017. Contingent upon the timing of the publication of these requirements, the SMA's goal is to have Stage 3 and Flexibility in place by April of 2017.

IAPD Submission Associated with System Changes

The HITECH IAPD for FFY 2017-2018 is currently under development. It is anticipated that it will be completed and submitted by December, 2016.

C.17 Interface Testing With CMS National Level Repository

(SMHP Companion Guide Question C #17)

AHCCCS began file exchange testing work with CMS for this program on October 1, 2010. Arizona was in the second group of states to test with the NLR which started in January 2011. AHCCCS has been capable *of interfacing with the CMS National Level Repository (NLR) since July 2011.*

There are no ongoing testing processes in place with the NLR; however, if a change is required, the SMA works with CMS technical staff to ensure successful implementation.

C.18 SMA Acceptance of Medicaid Provider NLR Registration Data

(SMHP Companion Guide Question C #18)

The AHCCCS program's plan for accepting the registration data for its Medicaid providers from the CMS NLR is through a communication protocol called Cyber Fusion. Cyber Fusion is a computer software tool used to securely transfer files between entities. It accepts the registration data from Medicaid providers from the CMS NLR. At this time the agency is reviewing its business operations and MITA State Self-Assessment results to identify any opportunities for interoperability. No plan exists at this time to implement interoperability between the SMA's HITECH systems and the T-MSIS and MACPro.

C.19 SMA Website Development for Medicaid Provider Engagement

(SMHP Companion Guide Question C #19)

Provider Engagement Regarding Enrollment, Program Detail, MU Stage Changes

AHCCCS staff are currently researching how other states engage providers related to MU Stage 3 changes and would like to add additional information about MU Stage Changes to the ePIP homepage in addition to updated provider reference guides.

Providers may sign on to the ePIP System at any time to get information about their attestation and payment status. The system will be used as a communication vehicle to provide updates and keep the provider informed. Once the provider completes the attestation process, ePIP will reflect messages indicating if an action is "In Progress" or "Completed". Both attestations and payments will be tracked in the ePIP.

The screenshot in the following figure is the first screen an EP would see after successfully registering with CMS and AHCCCS. This screen gives new providers the opportunity to register and registered providers the opportunity to log on and access to following options:

- *Manage My Account – where they can review & edit their contact information*
- *Attest – Where the provider can create & maintain attestations for separate program years*
- *Payments – Where providers can track payments for separate program years*
- *Manage Documents – Where providers can submit documents to support their attestation*
- *Log Off – EPs log out of ePIP*
- *EHR Certification Tool – Providers can validate their system's CMS EHR Certification ID before applying*

Figure 22: ePIP Home Page

C.20 SMA Anticipation of Modifications to MMIS

(SMHP Companion Guide Question C #20)

Anticipated SMA Changes to MMIS

At this time, the agency has not made any significant modifications to the MMIS environment so no MMIS IAPD has been requested for this program.

C.21 SMA Provision of a Help Desk

(SMHP Companion Guide Question C #21)

SMA Provision for Provider Questions Regarding the Incentive Program

The SMA has a dedicated email, phone, listserv and website for provider inquires and information. Providers can access the general program information at the Arizona website and contact the EHR Staff at:

- Email EHRIncentivePayments@azahcccs.gov
- EHR Help Desk 602-417-4333
- Website: http://www.azahcccs.gov/EHR/default.aspx
- Listserv: http://listserv.azahcccs.gov/cgi-bin/wa.exe?HOME

The SLR (ePIP) also displays basic messages regarding attestation and payment.

The provider can check the status of their attestation and payment by logging onto their ePIP accounts. If the provider's attestation data does not meet the program requirements, a message is displayed on the Attestation Status page. If the provider does not meet the MU requirements, the measures results are displayed on the MU Summary page.

AHCCCS has an approved contract with Arizona Health-e Connection to perform education and outreach for eligible providers. AzHeC recruits Medicaid providers, provides telephone and in person educational support for the EHR Incentive Program, as well as attestation support.

AHCCCS has included help at AzHeC that can assist providers who have questions about how to modify their workflow to be successful adopters of EHRs and for e-prescribing questions and support. These changes are in response to the findings from our online Provider Survey where providers expressed frustration with the current customer service limitations.

C.22 SMA Provision for Provider Appeal Regarding Eligibility, Payment, AIU

(SMHP Companion Guide Question C #22)

SMA Process for Provider Appeals

The SMA uses the existing provider grievance and appeal process, which was established in accordance with federal CMS requirements. The appeals process is managed by the AHCCCS Office of Administrative Legal Services (OALS) that coordinates with EHR Program Staff on all cases related to the EHR Incentive Program. Once an adverse decision is made by the EHR

Staff on an attestation, the provider is notified of the appeal process. Providers are able to work with EHR Staff throughout the entire process to help resolve any questions or concerns. Providers that choose to appeal must submit a written request to AHCCCS OALS as outlined in their Decision Notification. An appeal is a request from an EP and EH to reconsider or change a decision, also known as an action. Eligible providers may appeal all AHCCCS' adverse decisions. The provider may appeal any of the following decisions:

- Provider eligibility determinations
- Demonstration of adoption, implementation or upgrade of certified EHR technology
- Meaningful Use eligibility
- Denial of EHR Incentive Program payment
- Level or amount of payment
- Recoupment of payment

Request for an appeal must be sent within 30 days of the date of AHCCCS' notice.

C.23 SMA Accounting for Separation of HITECH and FFS Funds

(SMHP Companion Guide Question C #23)

SMA Process for Separation of HITECH and MMIS FFS Funds

The process AHCCCS will use to assure that all Federal funding, both for the 100% incentive payments as well as the 90% Administrative match are accounted for separately and not commingled with the MMIS FFP is that at this time the agency has not requested any MMIS funds for the HITECH program. All EHR program activity is tracked separately from other agency activities and is reported on the CMS 64 on its own line items.

C.24 SMA Anticipated Frequency of EHR Incentive Payments

(SMHP Companion Guide Question C #24)

Anticipated Frequency of EHR Incentive Payments by SMA

Batched payments to EPs and EHs are made monthly. These payments are made according to the statute and regulations of the Final Rule. The Medicare and Medicaid Extenders Act of 2010 (Public Law No: 111-309), enacted on December 15, 2010, amended the Health Information Technology for Economic and Clinical Health (HITECH) established by the American Recovery and Reinvestment Act of 2009.

C.25 SMA Verification of Payment to Provider without Deduction or Rebate

(SMHP Companion Guide Question C #25)

Incentive Payment without Deduction or Rebate

Providers that attest for the Medicaid EHR Incentive Program must complete their Payee NPI & Payee's TIN information in the CMS Registration & Attestation System. Payments are disbursed directly through electronic funds transfers to the Payee providing they are set-up in PMMIS.

Please note that payments under the Medicare and Medicaid EHR Incentive Programs will be treated like all other income. The incentive payment legal authorities do not supersede any State or Federal laws requiring wage garnishment or debt recoupment. Therefore, if there is a legal basis for the State or Federal government to net or recoup debts then such authority would apply to incentive payments, just as it applies to all other income.

C.26 SMA Verification Payments to Entities Supporting Adoption of CEHRT

(SMHP Companion Guide Question C #26)

Arizona does not have a State designated entity proving the adoption of CEHRT.

NOT RELEVANT FOR AN UPDATE PER COMPANION GUIDE

C.27 SMA Process of Fiscal Arrangements for Payment Disbursement

(SMHP Companion Guide Question C #27)

AHCCCS ensures that no EHR incentive payments go through the MCO capitation process because the incentive payments are being paid by the agency to the individual eligible professional and eligible hospital or as assigned. No funds are paid by the agency to MCOs for the EHR program

NOT RELEVANT FOR AN UPDATE PER COMPANION GUIDE

C.28 SMA Verification of Calculation and Payment Incentives are Consistent with Statute and Regulation

(SMHP Companion Guide Question C #28)

Verification of Calculation of Payment Incentive

AHCCCS will employ an automated process when determining the payment calculation for EPs & EHs to ensure statutory and regulatory requirements are met for the EHR Incentive Program. The payment determination for EPs and EHs are programmed in the State Level Repository (ePIP) system

.

Level 1: ePIP performs the 1st level payment calculation during the attestation process.

Level 2: The EHR Staff performs the 2nd level payment amount verification during Pre-Payment Audit process.

Eligible Professionals

EP EHR incentive payments are predetermined based on a scheduled of payments over six-years, as defined in the Final Rule.
The maximum payment amount over the six years is $63,750 for providers *(including Pediatricians)* who have a minimum 30% patient volume and disbursed as follows:

- $21,250 for Year 1
- $ 8,500 for Year 2, 3, 4, 5, 6 *(each payment year)*

For pediatricians (only) with a minimum 20% but less than 30% patient volume, the maximum payment is $42,500 and disbursed as follows:

- $14,167 for Year 1
- $ 5,667 for Year 2, 3, 4, 5, 6 *(each payment year)*

The provider can only receive an EHR payment from one State or Medicare/Medicaid program each payment year. The total amount paid cannot exceed the maximum payment amount.

Eligible Hospitals

EH EHR incentive payments are determined based on a formula and disbursed over four years, as defined in the Final Rule.

The Aggregate EHR Hospital Incentive Amount is calculated as the product of the Overall EHR Amount and the Medicaid Share. For each payment year, the EHR Incentive Program payment is based on a percentage *(defined by the State 40%, 30%, 20% & 10%)* of this Aggregate EHR Hospital Incentive Amount.

Dually eligible hospitals can only receive a Medicaid EHR incentive payment from one State each payment year. The total amount paid between Medicaid States cannot exceed the Aggregate EHR Hospital Incentive amount. Amounts are verified each application year and applicable re-calculations and adjustments are reconciled on all prior payments, as necessary

Since the Medicare Cost Report details are requested during the Post Payment Audit, all hospitals are subject to a 100% Post Payment Audit. A comprehensive four-year audit is also conducted prior to issuance of the forth EH payment.

Number of Negative Audit Findings and Lessons Learned

AHCCCS has been participating in an HHS – OIG Audit of its EHR Incentive Program for hospital payments. According to the report, AHCCCS was found to have made incorrect Medicaid EHRS Incentive Payments to 24 of 25 hospitals reviewed, totaling $14,953,577. These incorrect payments included both overpayments and underpayments resulting in a net overpayment of $14, 830,859. Because the incentive payment is calculated once and then paid out over 4 years, payments made after January 31, 2016 will also be incorrect. The adjustments to these payments total $1,674,728. According to HHS-OIG the errors occurred because hospitals did not always follow Federal and State requirements for calculating their incentive payments. In addition, the State agency did not review supporting documentation provided by the hospitals to help identify errors in their calculations.

AHCCCS did not agree with the HHS- OIG findings and AHCCCS is currently waiting for feedback from CMS and OIG related to its comments. The agency is prepared to amend its SMHP pending final conclusion of the audit. The agency has an updated Audit Strategy for the EHRS Incentive Program and it will be submitted separately to CMS either upon finalization of the HHS- OIG Audit findings or an interim strategy that can be amended once resolved.

Lessons learned related to the Audit findings will also be included once resolved.

C.29 Role of SMA Contractors in Implementing the EHR Incentive Program

(SMHP Companion Guide Question C #29)

SMA Contractor Roles in the EHR Incentive Program Implementation

AHCCCS is unusual in that much of the EHR Incentive Program's infrastructure has been performed by in-house agency staff. AHCCCS does not have an MMIS contractor. That work is done in-house. Modifications of the ePIP (EP portal) are done in-house. This past year, AHCCCS has used temporary staffing contracts if any extra administrative or programming services were needed to support the EHRS Incentive Program. Going forward the agency may need to increase the number and skill of contractors in order to ensure it is managing the program.

AHCCCS MCOs are involved in communicating pre-established information to the provider networks with which they contract and to direct providers to the AHCCCS website for more detailed information. AHCCCS MCOs are asked to indicate support for the implementation of EHRs in provider practices to improve the efficiency of health care and to improve clinical outcomes measures.

If the agency has a specific need that it cannot perform on its own or needs a subject matter expert it would contract with an organization to perform that special piece of work.

The agency did contract with Myers and Stauffer to support our EHRS Incentive Program Audit updates and to train staff on new pre and post payment auditing policies and procedures. The agency contracts with ASU/CHIR for a provider survey, Arizona Health-e Connection for Education and Outreach and temporary firms for extra administrative or specialty help. The

agency can initiate after receiving CMS approval amendments to state contracts for services that helps the EHR Program and can include RFP help, eCQM help and other specialty assistance.

C.30 Description of SMA Assumptions, Path, Timing and Planning Dependencies

(SMHP Companion Guide Question C #30)

SMA Planning Assumptions Regarding Path, Timing and Dependencies

CMS Dependency

AHCCCS depends significantly on getting adequate notice from CMS about program changes or rule changes as the Agency performs its own programming in house and does not participate with any of the large vendor sponsored communities like other SMAs.

State Assumption of Status/ Availability of EHR Technology

The SMA assumes that providers that want to participate in the Medicaid EHR Incentive Program have been contacted multiple times through the SMA Education and Outreach contract with Arizona Health-e Connection. This agreement is funding through the HITECH Program and is envisioned to be maintained through the end of 2021. The SMA assumes CMS will continue the certification of EHRs that most closely match the functionality of the MU criteria.

State Assumption of Regional Extension Centers and ONC HIE Cooperative Agreements

When the ONC grant programs ended, the SMA initiated a contract with Arizona Health-e Connection to provide some resources for Medicaid provider education related to the MU Program and through the SMA HIE Onboarding program the agency is helping to increase the number of Medicaid Providers that are connected to the state wide HIE.

State Specific Readiness Factors

Current Public Health Environment and Projected Timing

ASIIS is the statewide immunization registry for documenting immunization administration. ASIIS is accepting HL7 2.5.1 Immunization messages from any organization that is administering vaccinations to children or adults. Immunizations must be reported for patients aged 18 and under.

The Arizona Department of Health Services is currently accepting electronic immunization submissions to the Arizona State Immunization Information System (ASIIS) for Meaningful Use from all providers who administer adult or childhood vaccines. As of January 1, 2017 ASIIS will be ready for Meaningful Use Stage 3, including bidirectional capabilities allowing queries from EHRs.

As of October, 2016 ADHS is continuing its strategic planning efforts to identify opportunities where the HIE can facilitate electronic reporting. There is a pilot underway between The Network and ADHS that will determine the ability of ADHS to consume immunization data from The Network and to share immunization history back to The Network. The pilot is currently working to see if credentials can be exchanged and how best to exchange messages. This pilot is expected

to wrap up in February 2017, and to be fully implemented at The Network Public Health Gateway no later than June, 2017.

Funds will be requested in the next HITECH IAPD to facilitate the development and design and implantation of the Immunization Public Health Reporting Gateway.

ADHS expects to start testing for Electronic Lab reporting beginning in July 2017 with implementation by December 2017. After that, testing with Syndromic Surveillance is expected to start in January, 2018 with implementation by June, 2018. At this time no registries have been identified or created to be considered "specialized registries" under the MU Program. The one exception to this may be the Prescription Drug Monitoring Program, but as of today this has not been decided.

Delivery System Reform Incentive Payment (DSRIP) Program

Arizona has an application for DSRIP funding pending with CMS at the time of this submission. Should the application get approved, it is anticipated there will be additional funds that are expected to support more robust Health IT tools and services at The Network including population health and data analytics packages. If this funding is not received, these tools and implementation dates and users will need to be modified and updated. If approved funding was expected by early January 2017 to start.

Other EHR Program assumptions and/or operating decisions that Arizona has made include:

- **One Year Medicare Cost Report –** Arizona allows new hospitals to participate in the EHR Incentive Program with only one year of a Medicare Cost Report (MCR). Discharges from four MCRs are required to complete a final payment calculation; however, a minimum of one MCR is mandatory to calculate an initial payment amount. Payment reconciliations will be performed every year until a total of four MCRs are available to confirm appropriate payment amounts.

- **Forfeiture of Payments/Participation Year** – In the instance where AHCCCS determines that an EHR attestation was submitted using fraudulent data and/or with the intent to defraud the SMA, the offending provider (EP or EH) will lose a participation year from the EHR Incentive Program. If a payment has not been made, a denial notice will be sent, explicitly outlining the loss of the participation year. If a payment has been made, a recoupment will be issued and the loss of the payment/participation year will be clearly delineated in the recoupment letter. If CMS is the entity auditing and/or issuing a recoupment of funds for a provider, the provider will lose a participation year in alignment with CMS protocol.

- **Correctional Facilities and EHR Program Participation** – Arizona is still working with our correctional health partners to determine how they could participate in the EHRS Incentive Program. If appropriate AHCCCS plans to accept Program Year 2016 attestations. In order to establish Patient Volume, the SMA will be relying on statistical analysis of daily census reports that are gleaned from the patient volume period. The SMA will utilize internal data as well as data submitted from the correctional facilities to determine how many Medicaid Title XIX eligible (enrolled at the time of incarceration) members were receiving care from the correctional facility and for all subsequent services rendered by the correctional facility during the Patient Volume reporting period. This

method is being selected as all inmates, regardless of length of stay, are required to have at least one medical visit upon their incarceration; as health insurance information is not collected in this setting of care, the analysis of the daily census seems to be the most promising way to make an accurate determination of patient volume.

- **Group Practice Definition** (for the purposes of the EHR Incentive Program defined based on program administration in determining the Practice's Patient Volume)
  The lawful or legally standing business entity with legal capacity to operate as a Group Practice and with accountability for all business activity. The administration of the Arizona Medicaid EHR Incentive Program captures a single business entity linked by any or all of the following criteria:
  Single and/or multiple Employer Identification Number (TIN).
  Single and/or multiple National Provider Identifier (NPI)
  Single and/or multiple Group AHCCCS Provider Numbers (defined by AHCCCS Provider Registration)

  All sources of information are used to verify all providers associated to the Group Practice single business entity.

- **Determining Eligible Services for County Public Health Departments**

  The SMA could process applications for the EHR Incentive Program from county public health departments. In order to consistently and fairly evaluate the application, the SMA will exclude non-clinical services from the numerator and denominator when the county public health department delivers non-clinical services. Arizona is going to exclude from the numerator and denominator any services that are non-clinical, which may include the following:

  a. Farmers Market
  b. Community Nutrition Program Food Assistance
  c. Nutrition & Physical
  d. Senior Food Assistance
  e. WIC and Food Plus
  f. Child Car/Booster Seats
  g. Child Care Consultants
  h. First Things First
  i. Hand Washing
  j. Worksite Health
  k. Animal Care & Enforcement
  l. Child Care Health Consultants
  m. Childcare Inspection
  n. Consumer Product Safety
  o. Health Inspection
  p. Public Health Emergency
  q. Public Pool Inspection
  r. Restaurant Inspection & Ratings
  s. Smoke Free Arizona
  t. Mosquitos, Bed bugs, etc.

u. Birth Certificates
v. Child Care certificates
w. Health Inspection
x. Public Pool Inspection
y. Restaurant Inspection & Ratings
z. Complaints and Enforcement
aa. Found Pets
bb. Licensing
cc. Pet Adoptions
dd. Pet Vaccines
ee. Rabies
ff. Sheltering
gg. Spay/Neuter Clinics
hh. Vaccine Clinics
ii. Veterinary Clinics
jj. Or any other service or services that the County Public Health Department could document and attest to that are non-clinical.

- **EH Audits – Deferral to CMS**

Arizona has identified CMS as the lead auditor for dual eligible and Medicaid-only hospitals. Auditing determinations by CMS will be upheld.

- **Agency Interface with The Network (HIE)**

The agency has signed a participation agreement with Arizona Health-e Connection/The Network for the purpose of accessing and using patient data for care coordination activities. Currently, The Network's permitted use policies only allow its participants to use patient data for care coordination in the American Indian Health Program (AIHP). Once the Board of Arizona Health-e Connection approves other uses, AHCCCS would like to develop more robust data use and sharing with The Network for other administrative agency purposes such as eligibility determination and payment and program administration. Non-HITECH funds are used to support the ongoing agency connectivity to The Network.

American Indian Health Program (AIHP/Fee For Service) Population – Opportunity to improve Care Coordination.
The Agency has a Fee for Service Population which is primarily comprised of Medicaid members who qualify either for Federal Emergency Services Program (FES) or are Native American Indians that select the Fee for Service program instead of a Medicaid Managed Care Organization (MCO) for their care. The DFSM care managers are

permitted to use patient information in The Network to assist with coordinating care for AIHP members. Connectivity was established in September, 2016.

Future dependency at The Network is they must modify the current permitted use policy in order to allow for eligibility determinations in order for the agency to go forward and connect the CRS and LTC Program. At this time, the change to permitted use has not occurred. For the CRS program, since 2013, the AHCCCS staff has taken over the role of establishing and approving medical eligibility or redetermination eligibility for the CRS Program. Part of the program eligibility is based on an applicant's ability to document that they are diagnosed or being treated for one of the conditions identified in the CRS program. Information in The Network would help the agency be able to determine medical eligibility faster. Often times, the children have multiple specialists and treatment locations, so being able to securely receive this information from providers that are located across the state is important. Each applicant must have one of the specific conditions that are identified as an eligibility criteria for the CRS program before they can be enrolled.

The agency operates a Long Term Care program for members that meet both income and physical needs. AHCCCS staff perform a physical assessment of each applicant called a PASS assessment to see if the applicant meets the criteria. Patient data in The Network can help inform the eligibility of applicants for this program. It helps the AHCCCS staff to have access to a patient's health information in order to inform the PASS assessment.

The one time connectivity and ongoing operational funding for The Network for these purposes, is paid out of Non-HITECH funds. This is not considered eligible for HITECH funding so the agency anticipates identifying other funding in its HITECH IAPD. AHCCCS will be following The Network's "permitted use policy" for all of its agency activities.

Section D: The State's Audit Strategy – To be sent separately

D. SMA Methods to Avoid Improper Payments

(SMHP Companion Guide Question D)

SMA Methods to Avoid Improper Payments

The agency has invested significant resources in performing a comprehensive Pre-Payment Audit to validate provider attestations. In early 2015, the agency contracted with Myers and Stauffer to update its Audit Strategy and made comprehensive changes to its methods, timing, risk assessment, selection of audit elements in pre and post pay, proxy data, how the SMA will focus on audit efforts.

The Pre-Payment Audit process and all of the data elements it uses to validate provider eligibility are outlined in the new Audit Strategy toolkit was sent to CMS on Monday, November 30, 2015 and approved by CMS February 16, 2016.

Comprehensive audit strategy should be saved and submitted as a separate standalone document.

AHCCCS sent an Updated 2015 Audit Strategy document to CMS on Monday November 30, 2015 as a separate stand-alone document. AHCCCS is conducting a review of that that strategy through Myers and Stauffer, it's SME, and will forward that document as an independent submission following the submission of this SMHP.

D.1 SMA Methods Employed to Identify Fraud and Abuse

(SMHP Companion Guide Question D #1)

SMA Description of Methods to Identify Suspected Fraud and Abuse

Suspected fraud, waste or abuse may be detected at any point during the audit process. The Arizona Medicaid EHR Incentive Program policies and procedures include validation checks and audit controls throughout the entire process of the payment cycle, to identify potential fraud and abuse issues. At any time in the process, if fraud or abuse is suspected, The EHR staff submits all relevant details to the Office of Inspector General (OIG) Program Integrity Team pursuant to that office's guidelines.

The Department of Health Care Management Reimbursement Unit performs the Pre-Payment Audit. The Office of Inspector General performs the Post-Payment Audit. Debits and Credits for provider payments and recoupments will be made through the Department of Business and Finance and coordinated with the Information Services Division (ISD).

OIG is the office charged with the responsibility for conducting criminal investigations and investigative audits for all AHCCCS programs involving State and/or federal tax dollars. This office is also responsible for overseeing provider registration functions in the Arizona Medicaid program. The OIG is designated as a criminal justice Agency and is authorized by the FBI and the Arizona Department of Public Safety to access criminal justice information relevant to official investigations.

The office has statutory authority to issue subpoenas and place persons under oath to obtain evidence for investigations. Additionally, the unit works closely with federal, State and local law enforcement agencies in the detection, investigation and prosecution of any provider, subcontractor, member or employee involved in fraudulent activity involving the program. In addition to criminal investigations, OIG also issues and collects civil monetary penalties in accordance with federal and State statutes, rules and regulations.

AHCCCS currently tracks all supplemental payments to providers. The EHR incentive payments will be tracked with standard payment tracking procedures that are used for all other supplemental payments. In the event that AHCCCS recoups EHR funds:

- The EHR Staff (DHCM/OIG) issues a Notice of Recoupment demand letter to the provider and forwards a copy to the Payee and Division of Business and Finance (DBF), indicating the provider name, AHCCCS Provider Number, and any payments and/or amount to be recouped.
- ISD will process recoupments in ePIP and disburse payments to CMS and DBF
- DBF will load recoupment amounts into Arizona Financial Information System (AFIS) via the Invoice Files
- ISD will process recoupment amounts in the Invoice Files
- If funds are not received within 60 days, the EHR Staff sends a memo to OIG Investigative Unit that will include the following:
    - Provider attestation Details
    - Date of original payment
    - Reason for recoupment
    - Amount of recoupment
    - Correspondence regarding recoupment, communication with provider

Agency Use of Contractors

AHCCCS does not use contractors for identifying or reporting suspected fraud and abuse. Anytime the EHR Staff have a finding that raises a concern during any part of the payment cycle, the issue is sent to the AHCCCS Office of Inspector General (OIG) for research and follow-up.

Agency plans to incorporate findings from Audits to Address Fraud and Abuse

If at any time AHCCCS receives findings from its reports from the AHCCCS OIG office or the HHS Office of the Inspector General, these findings would be reviewed to see if changes or updates would be needed to the agency's pre and post payment activities.

Elements examined during the Pre-Payment Audit includes but not limited to:

- Provider Type
- Licensure
- Sanctions (State (MMIS), Regulatory Board, HHS-OIG (exclusions database)
- State Medicaid Provider
- Practice Location (Hospital-Based, Practice Predominantly and Physician Assistant)
- Patient Volume Type (Medicaid or Needy)
- Patient Volume Methodology (Individual)
- Patient Volume Methodology (Aggregate $_{\text{group proxy}}$)
- Patient Volume Out-of-State Patient Encounters
- Patient Volume Reports (including Hospital-Based & Practice Predominantly Reports)
- Hospital-Based Reports
- Practice Predominantly Reports
- MU & CQM Reports
- EHR Vendor Documentation (contract agreements, system certification requirements, etc.)
- Provider Re-assignment of EHR incentive payment
- Hospital Payment Calculation (initial determination based on MCR)
- Hospital Charity Reports
- Hospital Medicare Cost Reports (details reviewd at Post Payment Audit)

Elements examined during the Post-Payment Audit includes but not limited to:

- Any elements not reviewed during the Pre-Payment Audit
- Data variances greater than 20%
- Targeted Audits flagged during Pre-Payment Audit

- MU/CQM discrepancies between provider documentation and attestation
- Security Risk Assessment
- Hospital Charity Reports
- Hospital Financial Reports (detail trial balance reports, etc.)
- Hospital Medicare Cost Reports (details to support MCR)

D.2 SMA Method of Tracking the Total Dollar Amount of Overpayments

(SMHP Companion Guide Question D #2)

SMA Tracking of Overpayments and Reporting to CMS

The process for payments are coordinated by ePIP (invoice process), Medicaid Management Information System, EHR Staff, EHR Technical SME, Information Service Division (ISD), Division of Business & Finance (DBF) and Department of Administration Computer Operations (DOA OPS).

All providers that receive an EHR incentive payment are subject to review for improper payments. There are no limitations on the look back period for payment adjustments. Payment adjustments are either additional payment disbursements (+) or payment recoveries/recoupments (-).

Additional Disbursements
If the payment adjustment results in an additional disbursement, then the difference is reconciled and disbursed.

Recoupment
If the payment adjustment results in a recovery, the difference is reconciled and recouped.

Payments may be recouped in cases of Fraud, Waste, or Abuse or if the Post-Payment Audit determines the provider was ineligible for the EHR incentive payment.

Providers must remit payment to the State within 60-days of the Recoupment Notice.

The State must remit payment to CMS as soon as possible but no later than 60-days from discovery.

Reasons for Adjustments

A payment calculation can be adjusted for any of the following reasons:

- Appeal
- Audit
- Calculated Payment Amount Updated

- Recoupment
- Retraction

State Registration & Attestation System *(SR&A)*

ePIP is the Registration & Attestation System for the Arizona Medicaid EHR Incentive Program. ePIP is used to coordinate the provider registration, attestation and payment process. A successful submission of a provider attestation triggers the EHR incentive payment calculation.

CMS File Transfer Coordination (ISD)

Arizona uses the CMS file exchange process to prevent duplicate and improper payments. Payments for the Medicaid EHR Incentive Program must comply with the below *(included but not limited to)* requirements

Eligible Professionals:

EP payments are on a Calendar Year (CY) basis from January 1 – December 31 *(program application year)*.

EPs cannot receive payment for more than six program application years.

EPs cannot receive more than $63,750 for six program application years.

EPs may not begin participation in the EHR Incentive Program after the 2016 (CY) application year.

EPs may not receive payments for program application years after 2021 *(last year to apply)*.

EPs may receive one EHR incentive payment from only one State in a program application year.

EPs may be eligible for both Medicare EHR Incentive Program and the Medicaid EHR Incentive Program but may only participate and receive one EHR incentive payment from either program in a program application year.

EPs may switch once between the Medicare EHR Incentive Program and Medicaid EHR Incentive Program but the switch must occur before the 2015 application year.

EPs may elect to voluntarily re-assign their EHR Incentive Program payment to their employer at point of attestation (payee) who is has an AHCCCS Provider Number in the Medicaid Management Information System (MMIS).

EP or Payee must have an active Electronic Funds Transfer (EFT) record with AHCCCS in order to receive payments.

EP payments may be recouped in cases of fraud, abuse or if the Arizona State Medicaid Agency audit determines the provider was ineligible for the EHR incentive payment.

EPs suspected of fraud or abuse is reported to the Agency's Office of Inspector General (Medicaid Fraud Control Unit).

EP must agree to the below attestation disclaimer each time an attestation is submitted.

> *I certify that the foregoing information is true, accurate and complete. I understand that the Arizona Medicaid EHR Incentive Program payment will be paid from Federal funds, that by filing this attestation I am submitting a claim for Federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to*

obtain an Arizona Medicaid EHR Incentive Program payment, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

EPs are subject to audit by the Agency anytime an EHR incentive payment is disbursed and must agree to the below attestation disclaimer each time an attestation is submitted.

I understand that AHCCCS reserves the right to perform an audit of this information. The audit may include an on-site visit by AHCCCS staff or designee to gather supporting data. I hereby agree to keep such records as are necessary, for six years, to demonstrate that I met all Arizona Medicaid EHR Incentive Program requirements and to furnish those records to the Medicaid State Agency, Arizona Health Care Cost Containment System Administration (AHCCCS), or contractor acting on their behalf.

Eligible Hospitals:

EH payments are on a Federal Fiscal Year (FFY) basis from October 1 – September 30 *(program application year)*.

EHs cannot receive payment for more than four program application years.

EHs cannot receive more than the aggregate EHR incentive amount over four program application years.

EHs may not begin participation in the EHR Incentive Program after the 2016 FFY application year.

EH may not receive an EHR incentive payment after 2016 FFY unless the hospital received an EHR incentive payment in the prior FFY year.

EHs may not receive payments for program application years after 2019 FFY *(last year to apply)* based on Arizona's 4-year incentive disbursement period.

A multi-site hospital with one CMS Certification Number is considered one hospital for purposes of calculating the EHR incentive payment.

EHs may receive one Medicaid EHR incentive payment from only one State in a program application year.

EHs may be eligible for both the Medicare EHR Incentive Program and the Medicaid EHR Incentive Program. Hospitals that register only for one of the programs will not be able to manually change their registration (i.e., change to "Both Medicare and Medicaid EHR Incentive Program" or from one program to the other) after a payment is initiated. The EH must select "Both Medicare and Medicaid" during the Federal Registration process even if planning to apply only for one of the programs.

EH must have an active Electronic Funds Transfer (EFT) record with AHCCCS in order to receive payments.

EH payments may be recouped in cases of fraud, abuse or if the Arizona State Medicaid Agency audit determines the provider was ineligible for the EHR incentive payment.

EHs suspected of fraud or abuse is reported to the Agency's Office of Inspector General (Medicaid Fraud Control Unit).

EH authorized contact must agree to the below attestation disclaimer each time an attestation is submitted.

I certify that the foregoing information is true, accurate and complete. I understand that the Arizona Medicaid EHR Incentive Program payment will be paid from Federal funds, that by

filing this attestation I am submitting a claim for Federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain an Arizona Medicaid EHR Incentive Program payment, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

EHs are subject to audit by the Agency anytime an EHR incentive payment is disbursed and must agree to the below attestation disclaimer each time an attestation is submitted.

I understand that AHCCCS reserves the right to perform an audit of this information. The audit may include an on-site visit by AHCCCS staff or designee to gather supporting data. I hereby agree to keep such records as are necessary, for six years, to demonstrate that I met all Arizona Medicaid EHR Incentive Program requirements and to furnish those records to the Medicaid State Agency, Arizona Health Care Cost Containment System Administration (AHCCCS), or contractor acting on their behalf.

Provider Eligibility *(EHR Staff)*

The EHR Staff in DHCM performs the Pre-Payment Audit to determine the provider's eligibility. Payments for approved attestations are disbursement within 45 days after the approval date. If issues are encountered with the payment process, the payment request moves to a pend status until resolved. Attestations that are not approved remain on hold in ePIP until the provider is ready to re-submit a new attestation. A Notice of Decision is emailed to the provider.

Process for Recoupments

Pre-Payment Audit
The EHR Staff in DHCM Reimbursement Unit performs the Pre-Payment Audit to detect and prevent improper payments. At any time prior to the Post-Payment Audit, if an improper payment is detected, a Notice of Recoupment demand letter is initiated to the provider with copies sent to the Payee (if applicable) and Division of Business and Finance (DBF).

Post Payment Audit
The EHR Audit Staff in the Office of Inspector General division performs Post-Payment Audits to detect improper payments. At any time, if an improper payment results in a recoupment, a Notice of Recoupment demand letter is initiated to the provider, with copies sent to the Payee (if applicable), Division of Business and Finance (DBF), and Division of Health Care Management (DHCM).

Both Pre-Payment Audit & Post Payment Audit
The provider is directed to remit payment directly to DBF within 60-days from the date of notification or has the option to file appeal within 30-days. If the provider remits payment, DBF will record the payment in AFIS and notifies DHCM & Information Services Division (ISD) that payment has been received. ISD will record the recoupment in ePIP create an invoice adjustment on the ePIP Invoicing file and reports the recoupment to CMS on the CMS D-16 interface file transfer.

If payment is not received or an appeal is not filed within the above time frame, the EHR Staff will notify the OIG Program Integrity Team (PIT) of failure to repay the EHR incentive payment. OIG then follows standard operating procedures to collect the debt.

Payment Process

The Division of Business and Finance (DBF) processes payments through the Arizona Financial Information System (AFIS). Payments are made to the Payee's Taxpayer Identification Number (TIN) reflected in the CMS registration. Request for payments are tracked by a supplier number in the Arizona Financial Information System and by a vendor number in PMMIS. The vendor number is composed of the payee's AHCCCS Provider Number and location code that is tied to the payee's NPI & TIN.

Arizona only issues electronic payments once per month for the Medicaid EHR Incentive Program. Providers and/or payees are required to set-up an Electronic Funds Transfer (EFT) account in order to receive payment.

Payments cannot be made for negative amounts (recoupments), such amounts are saved in AFIS and offset by either future positive amounts (payment) or a remittance of the amount owed.

The EHR Staff initiates the payment process by releasing the hold in ePIP. This triggers a payment request on the CMS D16 interface file transfer. CMS must respond with an approval to initiate a payment record in the monthly ePIP Invoice process. Payment records are batched and collected until the monthly cycle engages.

The monthly payment processing cycle engagement triggers the following tasks:

(1) ePIP automatically generates the Invoice Files & ePIP Invoice Interface Report to DBF.

   (a) The Invoice Files are uploaded to an FTP site to be processed by the Arizona Financial Information System.

   (b) A notification email is sent to DBF EPEP Users indicating the Invoice Files are loaded at the FTP site for processing along with the ePIP Invoice Interface Report.

(2) The EHR Technical SME reconciles the expected payments against the CMS approved payments on the CMS D16 interface file and emails a payment certification statement to DBF.

(3) The ISD System Application Developer emails notification of the payment production run to the EHR Staff.

(4) The DBF Accountant performs the payment reconciliation between the ePIP Invoice Report and the payment certification statement. Differences found are escalated to ISD System Application Developer and the EHR Technical SME for resolution.

(5) The DBF Accountant completes and submits the AFIS PARM Form to the Department of Administration Computer Operations group (DOA OPS) to process the payments.

Please note that DBF has responsibility and oversight of the below tasks:

(1) Ensuring that the appropriate funding sources are used to make Medicaid EHR incentive payments.
(2) Following notification from DHCM and ISD, compliance with repaying CMS all Federal Financial Participation funds received by EP or EHs identified as an overpayment regardless of recoupment from such providers, within 60 days of discovery of the overpayment

D.3 SMA Process for Managing Detection of Fraud and Abuse

(SMHP Companion Guide Question D #3)

Process for Managing Fraud and Abuse When Detected

Suspected fraud, waste or abuse may be detected at any point during the audit process. The Arizona Medicaid EHR Incentive Program policies and procedures include validation checks and audit controls throughout the entire process of the payment cycle, to identify potential fraud and abuse issues. At any time in the process, if fraud or abuse is suspected, the EHR Staff submits all relevant details to the Office of Inspector General (OIG) Program Integrity Team pursuant to that office's guidelines.

The Department of Health Care Management Reimbursement Unit performs the Pre-Payment Audit. The Office of Inspector General performs the Post-Payment Audit. Debits and Credits for provider payments and recoupments will be made through the Department of Business and Finance and coordinated with the Information Services Division (ISD).

OIG is the office charged with the responsibility for conducting criminal investigations and investigative audits for all AHCCCS programs involving State and/or federal tax dollars. This office is also responsible for overseeing provider registration functions in the Arizona Medicaid program. The OIG is designated as a criminal justice Agency and is authorized by the FBI and the Arizona Department of Public Safety to access criminal justice information relevant to official investigations.

The office has statutory authority to issue subpoenas and place persons under oath to obtain evidence for investigations. Additionally, the unit works closely with federal, State and local law enforcement agencies in the detection, investigation and prosecution of any provider, subcontractor, member or employee involved in fraudulent activity involving the program. In addition to criminal investigations, OIG also issues and collects civil monetary penalties in accordance with federal and State statutes, rules and regulations.

D.4 SMA Intent Regarding Leveraging Existing Data Sources for verification of Meaningful Use.

(SMHP Companion Guide Question D #4)

Verification of Meaningful Use and CEHRT

The SMA will employ both automated and manual processes when performing the Pre-Payment Audit for EHR Technology documentation for EPs attesting to meaningful use of certified EHR Technology to ensure statutory and regulatory requirements are met for the EHR Incentive Program.

Level 1: ePIP (automated) performs the 1st level verification during the attestation process.

Provider attestations with an invalid EHR Certification Number result are automatically denied in ePIP. The SLR (ePIP) links to the ONC CHPL site to ensure that the EHR Certification Number being reported by the provider is for a valid, certified system.

Level 2: The EHR Staff (manual) performs the 2nd level verification during Pre-Payment Audit process.

The EHR Staff:
Reviews the EHR vendor documentation including but not limited to vendor contracts, purchase orders, billing invoices, screen shots of system version, etc.
Reviews the vendor documentation that demonstrates the CEHRT Edition certification requirements
Validates the vendor name for the EHR Certification Number
Reviews year-to-year consistency for EP vendors. If the provider switches vendor, they must provide updated supporting documentation for the new EHR vendor contract.
Reviews MU & CQM Reports to ensure the data entered in the MU portion of the attestation is correct.
If the result shows that the provider's EHR system did not meet the program requirements *(executed contract, appropriate CEHRT Edition certification requirements, correct MU & CQM Reports, etc.*) by December 31st of the Program Year in which the provider is applying, then the provider is not eligible.

At this time, all EPs who attest for MU Public Health measures, must keep paper copies and screen shots of their approvals they receive from the ADHS/Public Health agency. In the future, the agency would like to work with the HIE to ensure it can receive electronic confirmations/proof by each EP that they have met the required measures

In the future the agency will be working with its Health Plans and the HIE to better understand the existing data sources that could be made available to verify MU.

D.5 SMA Use of Sampling as Part of Its Audit Strategy

(SMHP Companion Guide Question D #5)

Sampling Methodology of the Audit Strategy

A risk-based approach is used for the post-payment audits to target providers that may pose an elevated risk of improper payments and noncompliance with the requirements of the Medicaid EHR Incentive Program. The EHR Audit Team gathers, analyzes data and conducts desk audits and/or on-site audits.

The audit selection process for providers is selected based on the sampling methodology table below. The EHR Audit Team may audit additional providers based on capacity. Using defined risk categories and thresholds, EPs receiving a Medicaid incentive payment will be subject to a post-payment audit.

Audits will generally start as desk audits. However, if compliance cannot be determined and the desk audit is deemed insufficient, an on-site audit will be scheduled with the EP or EH. The goal of the on-site audit is to support EPs and EHs to be in a position to adequately participate in the EHR Incentive Program.

Table 37: Risk Stratification Description

Risk Strata	Sampling Methodology
High Risk Providers	**All providers whose overall risk score is assessed as "high" will be selected for a post-payment desk audit.**
Medium to High Risk Providers	**A random sample of providers whose overall risk score is assessed as "medium-high" will be selected for a post-payment desk audit. The number of providers selected is the lower of 60% of the medium-high risk audit pool or 40 EPs.**
Medium Risk Providers	**A random sample of providers whose overall risk score is assessed as "medium" will be selected for a post-payment desk audit. The number of providers selected is the lower of 40% of the medium risk audit pool or 30 EPs.**
Low - Medium Risk Providers	**A random sample of providers whose overall risk score is assessed as "low-medium" will be selected for a post-payment desk audit. The number of providers selected is the lower of 20% of the low-medium risk audit pool or 30 EPs.**
Low Risk Providers	**A random sample of providers whose overall risk score is assessed as "low" will be selected for a post-payment desk audit. The number of providers selected is the 10% of the low risk audit pool.**

Data Source: AHCCCS EHR Program Audit Strategy September, 2016

D.6 SMA Methods to Relieve Provider Burden and Maintain Integrity and Efficacy of the Oversight Process

(SMHP Companion Guide Question D #6)

Plans to Reduce Provider Burden by Use of Existing Data and Leveraging SMA Audit Mechanisms

AHCCCS will rely on existing data to reduce provider burden and maintain integrity and efficacy of oversight processes. For instance, AHCCCS plans to use provider data in PMMIS to verify provider eligibility and to calculate projected patient volume percentages as well as verify reasonableness of Meaningful Use measure data.

D.7 Program Integrity Operations Locations

(SMHP Companion Guide Question D #7)

Revision of Incentive Payment Oversight

The SMA's EHR Incentive Program responsibility for program integrity is divided between two different divisions**.**

- Division of Health Care Management (*Pre-Payment Audit)*

  The Division of Health Care Management (DHCM) performs the Pre-Payment Audit procedures on provider attestations and also refers any suspicious activity to the SMA Office of Inspector General (OIG) Program Integrity Team.

- *Office of Inspector General (Post Payment Audit)*

  The Office of Inspector General (OIG) performs the Post Payment Audit procedures on provider attestations and also refers any suspicious activity to the SMA Office of Inspector General (OIG) Program Integrity Team.

  The SMA Office of Inspector General (OIG) is responsible for program integrity by preventing, detecting and investigating fraud and abuse through the Provider Compliance Division Investigative Analysis Unit, Investigations Unit and Provider Registration Units. The OIG Provider Registration Unit are responsible for conducting OIG, state, and medical board sanctions and keeping provider information up to date in PMMIS so that excluded or suspended providers are flagged.

Both the Pre-Payment Audit and the Post Payment Audit teams are responsible for implementing and updating the agency's EHR Incentive Program Audit Strategy.

Section E. The State's HIT Roadmap

E.1 SMA Graphical/Narrative Pathway from "As Is" to "To Be"

(SMHP Companion Guide Question E #1)

"As Is" and "To Be" Pathway

Over the next five years, the agency is expecting almost 100% of all Medicaid providers to be using an EHR and participating in secure health information exchange. With this degree of Health IT deployment, the agency will be focused on leveraging all of the Health IT investments made through the HITECH Program with the goal of reducing care and coverage fragmentation for Medicaid members.

The agency has 3 goals it is using to improve care coordination and reduce care fragementation:

Goal 1: Oversee and Administer the EHR Incentive Program

Goal 2: Increase Agency Use and Support for HIT/HIE

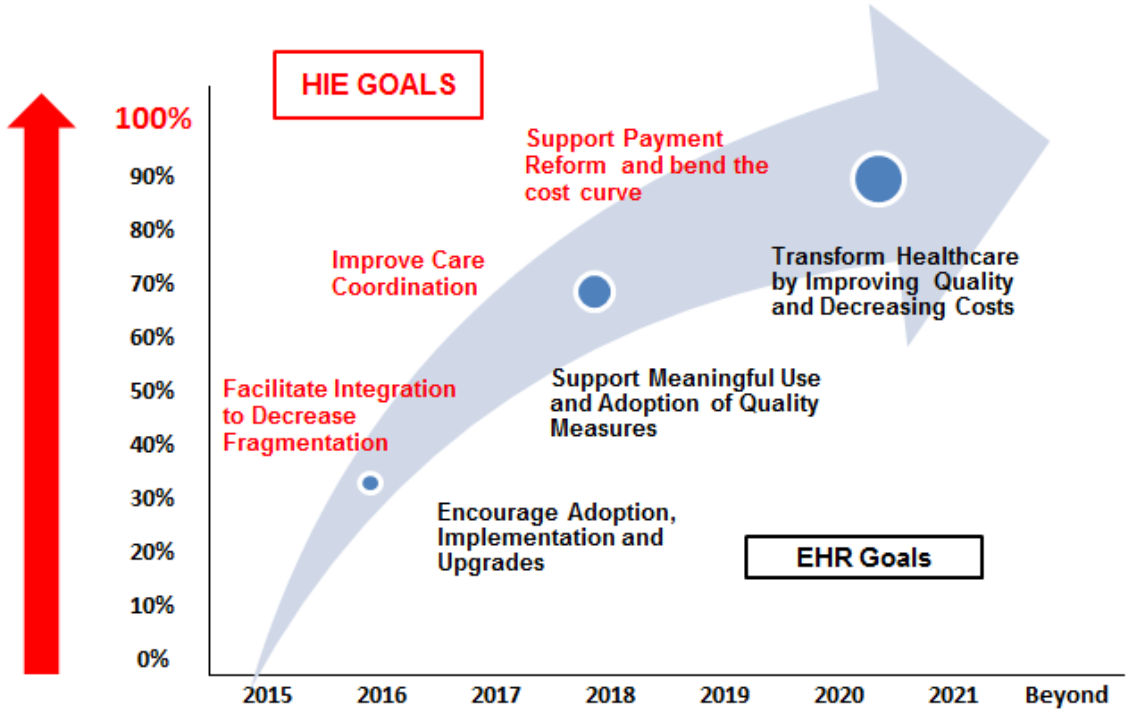
Goal 3: Accelerate Statewide HIE Participation by all Medicaid Providers and Plans

The figure below represents the graphical expectation that almost 100% of physicians in Arizona are expected to be using an Electronic Health Record by 2018. The immediate focus for the agency is recruiting eligible professionals to the EHR Incentive Program to enable the "data capture" phase of the MU program.

By the end of 2016, it is expected that more providers would be positioned to focus on health information exchange (HIE) due to their EHR adoption and the continued maturity and robustness of The Network and its stakeholders.

Through policy efforts at the agency like requiring health plans to have e-prescribing goals, having them join The Network to access real time clinical data for care coordination, and additional discussions about payment reform opportunities, the agency expects that by 2020 each plan will be able to demonstrate care improvements and be able to bend the cost curve.

Figure 23: SMA Graphic "As Is" and "To Be"



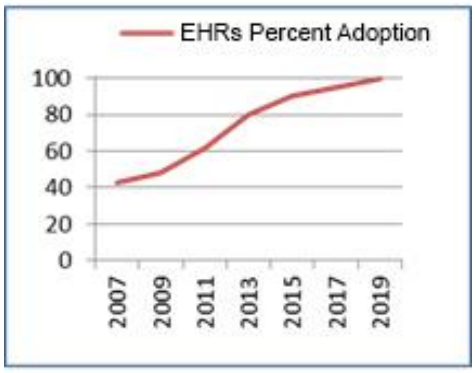
E.2 SMA Expectations Regarding Provider EHR Technology Adoption over Time

(SMHP Companion Guide Question E #2)

SMA Expectation of Provider EHR Adoption

According to the researchers at Arizona State University/Center for Health Information Research (CHIR) it is expected that by 2018 almost 100% of physicians are expected to be using an electronic health record. The chart below provides a visual of this expectation.

Figure 24: Projected Arizona EP EHR Adoption Percentage By 2018



Growth in EHR Adoption Rate

Source: ASU Center for Health Information and Research

Benchmarks for SMA Goals in Registration and Participation

Increase the Adoption of EHR by EPs and EHs

In addition to Agency long-term goals for their EHR Incentive Program, AHCCCS is committed to encouraging EHR and HIT adoption for eligible providers in the next five years. The following table provides an overview of the projected number of EPs in Arizona expected to apply and qualify for the EHR Incentive Program.

According to the projections in the table below, AHCCCS EHRS Goals for Eligible Professionals, by 2020, AHCCCS projects it will have 5,360 EPs registered in the EHR Program with 70 % of them receiving an AIU Payment. 3,075 EPs will receive an MU 1 Payment and 2,176 EPs will receive an MU Stage 2 Payment. It is projected that by CY 2020, 1,500 providers will have received a stage 3 payment.

(Section E.2 Continued)

Table 39: AHCCCS EHR Goals for Eligible Professionals

AHCCCS Goals for Eligible Professionals EHR Adoption, Meaningful Use Program Metrics FFY 2015-2020						
	CY 2015	*CY 2016 Estimates*	*CY 2017 Estimates*	*CY 2018 Estimates*	*CY 2019 Estimates*	*CY 2020 Estimates*
EP Registered in ePIP	*4,893*	*5,360*	*5,360*	*5,360*	*5,360*	*5,360*
EP Receive AIU payment	*3,113*	*3,574*	*3,760*	*3,760*	*3,760*	*3,760*
Registered EP Received AIU Payment	*63.62%*	*66.68%*	*70.15%*	*70.15%*	*70.15%*	*70.15%*
EP Receive MU Stage 1 Payment	*883*	*1,401*	*1,575*	*2,075*	*2,575*	*3,075*
Successful AIU EP Received MU1 Payment	*28.36%*	*39.20%*	*41.89%*	*55.19%*	*68.48%*	*81.78%*
EP Receive MU Stage 2* Payment	*0*	*42*	*676*	*1,176*	*1,676*	*2,176*
Successful MU Stage 1 EP Received MU Stage 2 Payment	*0.00%*	*3.00%*	*42.92%*	*56.67%*	*65.09%*	*70.76%*
EP Receive MU Stage 3 Payment	*0*	*0*	*0*	*500*	*1,000*	*1,500*
Successful MU Stage 2 EP Received MU Stage 3 Payment	-	*0.00%*	*0.00%*	*42.52%*	*59.67%*	*68.93%*

Data Source: DHCM EHRS Program, November 2016

EHR Incentive Program Registration and Payments for Eligible Hospitals

The table below reflects EHR Goals for Eligible Hospitals until CY 2020. Projections include 76 EHs will be registered in ePIP, 97 % of the EHs will receive an AIU payment, 72 EHs will receive an MU Stage 1 and Stage 2 Payment and that 4 hospitals will have attained Stage 3 MU.

(Section E.2 Continued)

Table 40: AHCCCS EHR Goals for Eligible Hospitals

AHCCCS Goals for Eligible Hospitals EHR Adoption, Meaningful Use Program Metrics FFY 2015-2020						
	FFY 2015	*FFY 2016*	*FFY 2017 Estimates*	*FFY 2018 Estimates*	*FFY 2019 Estimates*	*FFY 2020 Estimates*
EH Registered in ePIP	*75*	*76*	*76*	*76*	*76*	*76*
EH Receive AIU payment	*72*	*72*	*74*	*74*	*74*	*74*
Registered EH Received AIU Payment	*96.00%*	*94.74%*	*97.37%*	*97.37%*	*97.37%*	*97.37%*
EH Receive MU Stage 1 Payment	*61*	*61*	*72*	*72*	*72*	*72*
Successful AIU EH Received MU1 Payment	*84.72%*	*84.72%*	*97.30%*	*97.30%*	*97.30%*	*97.30%*
EH Receive MU Stage 2* Payment	*3*	*16*	*64*	*69*	*71*	*72*
Successful MU Stage 1 EH Received MU Stage 2 Payment	*4.92%*	*26.23%*	*88.89%*	*95.83%*	*98.61%*	*100.00%*
EH Receive MU Stage 3 Payment	*0*	*0*	*0*	*2*	*3*	*4*
Successful MU Stage 2 EH Received MU Stage 3 Payment	*0.00%*	*0.00%*	*0.00%*	*2.90%*	*4.23%*	*5.56%*

Data Source: AHCCCS EHR Team November, 2016

E.3 Annual Benchmarks for each of the SMA Goals

(SMHP Companion Guide Question E #3)

AHCCCS described its EHR Program Registration and Payment metrics in the previous question (E.2). Other benchmarks for each goal are identified below:

AHCCCS Goal 1: Oversee and Administer the EHR Incentive Program

a. *Ensure Providers Migrate Through the MU Continuum (Refer back to Question E.2)*

b. *Support ADHS Public Health Onboarding for MU Measures*

    i. *Benchmark: Allow providers to submit immunizations electronically by July 1, 2017.*

c. *Achieve Program Integrity Goals*

    i. *Update Agency Audit Stratgy to comply with HHS OIG findings by June 1, 2017*

AHCCCS Goal 2: Increase Agency Use and Support for HIT/HIE

a. *Care Coordination between Physical and Behavioral Health Providers*

    i. *Add 2 new integrated FQHCS/RHCS clinics to the EHR Incentive Program*

    ii. *Pay 4 New FQHCS/RHCS an EHR Incentive Payment by March 2017.*

    iii. *Increase the number of BH providers who get connected under the State Health Integration Plan (SHIP) from current 38 to 60 by December 2017.*

b. *Support AHCCCS Payment Modernization Initiatives and Adminstrative Efficiency Projects*

    i. *Of the 42 hospitals that have qualified for an increase in their payments due to meeting MU 2 and having established connectivity with the HIE, track the amount of additional funding that is generated for hospital.*

c. *Implement the American Indian Health Home Waiver*

    i. *Have 3 care collaboratives established for AIHP members by July, 2018*

d. *Improve Care for Children with Behavioral Health Needs Including those at Risk and Engaged in the Child Welfare System*

    i. *Have 15 community providers that are experts in Autism Spectrum Disorder Connect to The Network by July, 2018*

AHCCCS Goal 3: Accelerate Statewide HIE Participation for All Medicaid Providers and Plans

a. *Expand the HIE Onboarding Program for Medicaid Hospitals, FQHC's, RHC's, Groups and All Other Medicaid Providers.*

    a. *Onboard up to 70 different Medicaid Provider Organizations by end of FFY 2018 including eligible and non- eligible providers*

b. *Monitor Annual HIE Benchmarks (see below for current milestones)*

HIE Annual Benchmark Report

As required by CMS, AHCCCS is enclosing a summary of the Arizona State Leve HIE Annual Benchmark Report for The Network. The HIE Annual Benchmark report covers the time period of July 1 2015 – June 30, 2016.

HIE Annual Contributions

The total contributions to The Network from Hospitals and Other Providers = $783,368 (30%)

Health Plans = $1,053,240

AHCCCS /HIE Onboarding Funding = $661,667

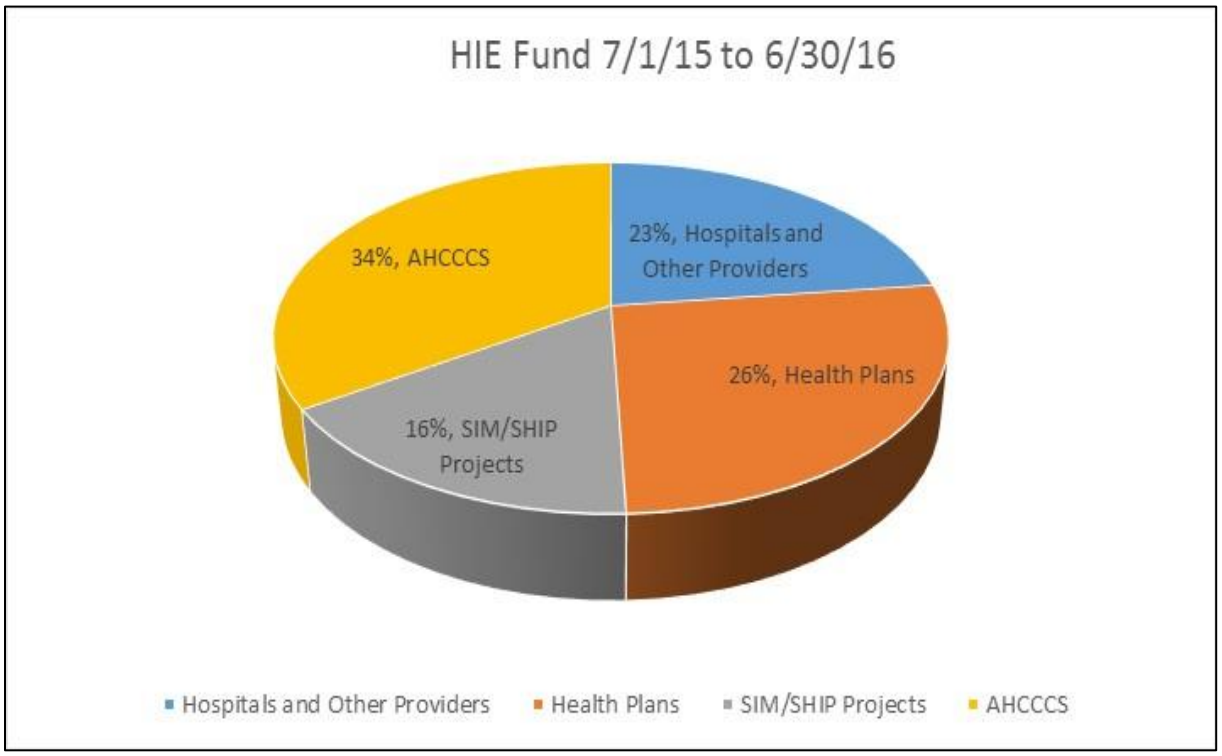
Regional Extension Center = $99,530

Total = $2,597,805

The figure below graphically demonstrates the sources of funding for the for the state level health information exchange.

(Section E.3 Continued)

Figure 25: Payer Contributions to the HIE



Data Source: Arizona Health-e Connection, November, 2016

HIE Annual Benchmark Successful Connections:

The following section details the number and type of Organizations that have become participants in the state level Health Information Exchange (The Network). A full listing of participants is included in Appendix F:7.

The following connections have been made as of 11/14/2016:

- *Accountable Care Organizations (8)*
- *Behavioral Health Providers (69)*
- *Community Providers (62)*
- *FQHC and Community Health Centers (21)*
- *Health Information Exchanges (2)*

- *Health Plans (13)*
- *Hospitals and Health Systems (22)*
- *Labs and Imaging Centers (2)*
- *Long Term and Post-Acute Care (11)*
- *State and Local Government (14)*

Total Number of Active Participants in The Network as of November 14, 2016 = 224

Note that not all organizations that have become participants have yet connected to The Network for data exchange.

HIE Annual Benchmark Covered Lives:

Total Number of patients with clinical data = 6.2 million.

The total number of lives in Arizona is 6. 8 million Residents in Arizona

% of Arizonans with clinical data in The Network = 91% of population

HIE Annual Benchmark and HIE Onboarding Goal Progress

The numbers below specify milestones of implementation achieved by organization type and subsidized through HITECH funds.

Note that not all participants in the in the HIE are eligible for subsidy.

The total number of Hospitals/Health Systems participating with The Network = 21

- *Milestone 1: 1*
- *Milestone 2: 14*
- *Milestone 3: 6*
- *Milestone 4: 6*
- *Milestone 5 : 0*

Total Number of FQHCS/RHCS/Look A-likes Participating with The Network = 18

- *Milestone 1: 7*
- *Milestone 2: 10*
- *Milestone 3: 1*

- *Milestone 4: 1*
- *Milestone 5: 0*

Total Number of Community Providers Participating with The Network

- *Milestone 1: 4*
- *Milestone 2: 0*
- *Milestone 3: 0*
- *Milestone 4: 0*
- *Milestone 5: 0*

(Section E.3 Continued)

Financial Status – See Appendix F.5 in Reference to the HIE Audited Financial Statement

Electronic Quality Measures

- *To Be Determined: Under Development*

Progress in Enabling MU Such as Public Health Facilities and Transmission of Summary of Care Records

As of October, 2016 ADHS is continuing its strategic planning efforts to identify opportunities where the HIE can facilitate electronic reporting. There is a pilot underway between The Network and ADHS that will determine the ability of ADHS to consume immunization data from The Network and to share immunization history back to The Network. The pilot is currently working to see if credentials can be exchanged and how best to exchange messages. This pilot is expected to wrap up in February 2017, and to be fully implemented at The Network Public Health Gateway no later than June, 2017.

Funds will be requested in the next HITECH IAPD to facilitate the development and design and implantation of the Immunization Public Health Reporting Gateway.

(Section E.3 Continued)

Identify Changes in Leadership

By the end of 2015, the Health Information Network of Arizona Board was dissolved and merged fully with Arizona Health-e Connection to improve efficiencies and provide full management oversight of the state level HIE called "The Network". AzHeC has kept a Network Leadership Council which has participants with deep technical expertise to advise The Network on its implementation plans. Its composition is detailed in Section A.7 and the purpose of the NLC is to provide information technology expertise and oversight to The Network.

The table below is a summary of all of the HIE Annual Benchmarks from The Network as of June 30, 2016.

Table 41: HIE Annual Benchmarks as of June 30, 2016

HIE Annual Benchmarks - Contributions	Identify all other payers and how much they have contributed to the HIE. Specify whether it was direct funding and/or in-kind each year. Please provide details. High-level pie chart	**Total Contributions 7/1/15 to 6/30/16** • Hospitals & Other Providers = $1,066,249 (23%) • Health Plans = $1,222,838 (26%) • AHCCCS = $1,589,341 (34%) • SIM/SHIP Projects = $755,341 (16%) • TOTAL = $4,633,168
HIE Annual Benchmarks - Successful Connections	Provide the cumulative number and % of total providers successfully connected to the HIE each year overall.	**Total HIE Organizational Participants and Connections to The Network as of 06/30/16** There are 186 organizations who have signed Participation Agreements with The Network. They currently represent: 1. Total number of Hospitals = 21 a. Total Number of CAHs = 6 b. Total Number of IHS/638 = 0 c. Currently represents 91% of hospital discharges in Arizona 2. Total Number of FQHCs = 16 3. Total Number of Rural Health Centers = 2 4. Total Number of Health Plans = 13 a. AHCCCS Health Plans = 11 b. Commercial Health Plans = 2 5. ACOs & CINs = 4 6. Community Providers = 110 a. Physical Health Providers = 49 b. Behavioral Health Providers = 61 7. Post-Acute & Long Term Care Providers = 8

	Provide the same for total Medicaid providers, and of those, separate by Medicare, Medicaid Eligible Hospitals, or EPS	8. County Corrections = 2 9. Fire-Medical = 3 10. Labs = 2 11. HIEs = 3 12. State & Local Government = 2 **The following connections have been made as of 6/30/16:** 1. Hospitals = 20 2. FQHCs = 5 3. Rural Health Clinics = 2 4. AHCCCS Health Plans = 4 5. Commercial Health Plans = 2 6. ACOs & CINs = 1 7. Community Providers = 9 8. Post-Acute & Long Term Care Providers = 1 9. County Corrections = 2 10. Fire-Medical = 3 11. Labs = 1 12. HIEs = 3 13. State & Local Government = 0 **At this time The Network is unable to distinguish the number of providers by payment source such as Medicare, Medicaid Eligible Hospitals, or EPs.**
HIE Annual Benchmarks - Covered Lives	Provide cumulative number and % of total Medicaid covered lives. Provide context needed to understand the growth or lack of growth (may include Medicaid providers: accessing the HIE viewer to get information, receiving hospital alerts from provider notification services, sending data to the HIE from their EHR or having a direct account regardless of how it is used.	**The breakdown of Medicaid covered lives is currently not available.** The Total number of patients with clinical data as of June 30, 2016 is 6.4 million this up from the 3.9 million from the prior year. During the period of this report the following new HIE services were added through the new HIE platform: • **899,889** patient ADT Alerts and Clinical Notifications were delivered • **51,110** patient records were viewed via the HIE provider portal
HIE Annual Benchmarks – HIE Goal Progress	In Appendix D, provide a status update on meeting the proposed 90/10 Subsidy Program FFY 10/1/15 – 9/30/16 goals	**Recruitment:** 1. Large hospitals and health systems 2. Medium hospitals 3. Small and critical access hospitals

		4. FQHCs and RHCs **Unidirectional Exchange with The Network:** 1. Large hospitals and health systems 2. Medium hospitals 3. Small and critical access hospitals 4. FQHCs and RHCs **Bidirectional Exchange with The Network:** 1. Large hospitals and health systems 2. Medium hospitals 3. Small and critical access hospitals 4. FQHCs and RHCs
HIE Annual Benchmarks - Financial Status	Provide prior year's financial statement for the HIE plus any other details to help explain financial status	Completed. See audited financial statements for 2015.
HIE Annual Benchmarks - Electronic Quality Measures	Provide information on progress for using the HIE to capture clinical quality measures electronically from EHRs for Medicaid providers participating in the Medicaid EHRs incentive program	Currently no Medicaid providers are submitting clinical quality measures to the HIE as this service is not currently available.

Data Source: Arizona Health-e Connection, June 2016

(Section E.3 Continued)

The table below is a projection of Recruitment and Interfaces that The Network anticipates accomplishing for FFY 2017 and for FFY 2018. ***For Milestone 1****:* ***Recruitment****, The Network expects to recruit at least 75 different eligible Medicaid Provider Organizations to The Network during each Federal Fiscal Year. For a two year total of 150 additional organizations.*

For Milestone 2- Participant Data to The Network*, AzHeC expects to build 35 interfaces using HL7 and 29 organizaitons would be vendor hosted cloud- based services sending a CCDA/CCD encounter summary via a single Interface .*

For Milestone 3*-* ***The Network Data to Participant****, AzHeC has planned that 5 hospital organizations will use Query-Response non-eHealth Exchange interfaces. 70 provider practices are expected to establish Alerts & Notifications including DIRECT Secure Email and Provider Portals*

For Milestone 4- Participant Incentive Subsidy*, AzHeC is anticipating that 5 Hospitals will receive an incentive subsidy in FFY 2017 and an additional 5 Hospitals in FFY 2018. AzHeC is planning that 19 Community provider practices will receive an incentive payment in FFY 2017 and 19 in FFY 2018 with. These practices are expected to be small numbering only 1 to 10 providers. For practices with 11 to 25 providers, AzHeC anticipates 19 in FFY 2017 and FFY 2018 will receive a subsidy and finally for large practices with more than 26 providers, AzHeC anticipates thre being 21 in FFY 2017 and 21 in FFY 2018 that qualify for a participant subsidy.*

For Mileston 5 –*There are currently no milestone payments identified at this time for services listed under this milestone.*

The total amount of HIE onboarding subsidies being requested from AHCCCS will equal $4.2 million to accommodate these milestones. The table below provides the detail to this description.

(Section E.3 Continued)

Table 42: Proposed 90/10 Subsidy Program Fees

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Milestones & Options	Milestone Fee	FFY 2017	FFY 2018
Total Program Fees:		$4,200,000	$4,200,000
#1 – Recruitment:			
Includes all recruitment activities, fully executed agreements, patient consent guidance, and workflow review and redesign support (5 hospitals & 70 practices)	$15,000	75	75
#2 – Participant Data to The Network - Options:			
A. Interface Development: HL7 v2 Data Feed to The Network - all transactions types (15 practices)	$20,000	15	15
B. Interface Development: HL7 v3 or CCDA Data Feed to The Network - all transactions types(15 practices)	$22,000	15	15
C. Interface Development: HL7 v2 Data Feed to The Network for ADT transactions only Plus: Interface Development: Query-Response (non-eHealth Exchange) to supply the remaining Lab, Rad and Transcription transactions (5 hospitals)	$35,000	5	5
D. Interface Development: HL7 v3 or CCDA Data Feed to The Network for ADT transactions only Plus: Interface Development: Query-Response (non-eHealth Exchange) to supply the remaining Lab, Rad and Transcription transactions	$37,000		
E. Interface Development: HL7 v2 Data Feed to The Network (for ADT, Lab, and Rad transactions) Plus: Interface Development: Inbound to The Network using XDS.b protocol (for all transcribed documents)	$50,000		

(Table 42 Continued)

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Milestones & Options	Milestone Fee	FFY 2017	FFY 2018
F. Interface Development: HL7 v3 or CCDA Data Feed to The Network (for ADT, Lab, and Rad transactions) Plus: Interface Development: Inbound to The Network using XDS.b protocol (for all transcribed documents)	$50,000		
G. Interface Development: Direct Secure Email to The Network with CCDA/CCD encounter summary	$19,500		
H. Interface Development: Vendor hosted cloud-based service sending a CCDA/CCD encounter summary via a single interface (30 practices)	$5,000	29	29
#3 – The Network Data to Participant - Options:			
A. Interface Development: HL7 v2 Data Feed from The Network - all transactions types (10 practices)	$22,000		
B. Interface Development: HL7 v3 or CCDA Data Feed from The Network - all transaction types (10 practices)	$27,000		
C. eHealth Exchange: Query-Response	$25,000		
D. Interface Development: Query-Response non-eHealth Exchange (5 hospitals)	$45,000	5	5
E. Alerts & Notifications includes Direct Secure Email & Provider Portal (70 practices)	$20,000	70	70
F. Interface Development: Direct Secure Email from The Network with CCDA/CCD encounter summary	$13,500		
G. Interface Development: Vendor hosted cloud-based service receiving a CCDA/CCD encounter summary via a single interface (30 practices)	$5,000		

(Table 42 Continued)

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Milestones & Options	Milestone Fee	FFY 2017	FFY 2018
#4 – Participant Incentive Subsidy:			
1. Hospital Incentive Payment	$20,000	5	5
2. FQHC & RHC Incentive Payment	$10,000		
3. Community Provider Incentive Payment (practices of 1 to 10 providers)	$5,000	19	19
4. Community Provider Incentive Payment (practices of 11 to 25 providers)	$5,000	19	19
5. Community Provider Incentive Payment (practices of 26+ providers)	$10,000	21	21
#5 – Optional Meaningful Use Support Services (Fees are per entity; all combinations allowed):			
1. Direct Accounts Only (for transport between providers)	$5,000		
2. Public Health: Immunizations	$15,000		
3. Public Health: Reportable Labs	$30,000		
4. Public Health: Syndromic Surveillance	$23,000		
5. Public Health: Disease Registries (per registry)	$17,000		

E.4 Annual Benchmarks for Audit and Oversight Activities

(SMHP Companion Guide Question E #4)

AHCCCS is committed to ensuring program integrity and conducting comprehensive audit and oversight activities. AHCCCS updated its EHR Incentive Program Strategy and received CMS approval on the new Audit Strategy in February 2016. This ensures the SMA is overseeing the EHR Program.

The EHR Incentive Program includes a significant number of requirements, many of which are evaluated prior to payment by the Arizona Electronic Health Record (EHR) Incentive Program staff. Pre-payment evaluations by EHR Program staff include review of provider compliance with requirements for:

- Hospital -based status, Medical license status, and Provider type
- Valid payee information and Medicaid patient volume or Needy Individual patient volume
- Valid CMS Certification ID for the certified EHR technology (CEHRT);
- Limit of one payment per provider per year (completed in conjunction with CMS); and
- Licensure exclusion status both in Arizona and other states, if applicable.

In addition to pre-payment checks, the SMA performs Post Pay Audits on random samples by program year and according to our risk stratification strategy contained in our approved Audit Strategy. The table below is a summary of our post pay audit benchmarks.

Table 43: Predicted Audit and Oversight (under existing Audit Strategy) will be updated upon approval of new Audit Strategy submission that is pending with CMS

Predictive Audit and Oversight Cumulative Annual Benchmarks				
	Program Year 2011/2012 (PY11/12)	**Program Year 2013 (PY13)**	**Program Year 2014 (PY14)**	**Program Year 2015 (PY15)**
Eligible Professionals (EP)	118	TBD	TBD	TBD
Eligible Hospitals (EH)	72 total and some have multiple yrs. to be audited	TBD	TBD	TBD
EPs (IHS/638/FQHC)	721	TBD	TBD	TBD

(IHS/638/FQHC) ONLY for program years 2011 and 2012 we are doing 100% audit as these were pretty much passed through with little verification on the pre-pay side.

Data Source: Post Payment Audit Team – OIG AHCCCS, October 2016

Section:F Appendices

Appendix	Item
F.1	Acronyms
F.2	Description of AHCCCS Executive Offices and Divisions
F.3	Flexibility Amendment Planning and Approval
F.4	Environment Scan EP Online Survey – Full Survey Questions
F.5	Appendix F.5 HIE Audited Financial Statement (Separate Attachment) Please note that the following appendix is not included in this document due to size and can be viewed separately.
F.6	Section F.6 Identifies the top 100 Arizona behavioral health community providers who have been designated by the Statewide HIE Integration Plan (SHIP) to be integrated into the statewide health information exchange. Arizona's three Regional Behavioral Health Authorities have funded this integration.
F.7	Section F.7 Provides a listing of contracted participants, by count and type, that are members of The Network, the state level health information exchange.

Appendix F.1: Acronyms

Acronym	Definition
ACE	AHCCCS Customer Eligibility
ADHS	Arizona Department of Health Services
AHCCCS	Arizona Health Care Cost Containment System
AI / AN	American Indian / Alaska Native
AIU / AIU1	Adoption, Implementation or Upgrade; AIU for first year
ARRA	American Recovery and Reinvestment Act
ASIIS	Arizona Statewide Immunization Information System
ASET	Arizona Strategic Enterprise Technology
ASU-BMI	Arizona State University's Department of Biomedical Informatics
AzHeC	Arizona Health-e Connection
CAH	Critical Access Hospital
CCN	CMS Certification Number
CHIP	Children's Health Insurance Program (also known as KidsCare in Arizona)
CIO	Chief Information Office
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year (used by Eligible Professionals)
DBF	Division of Business & Finance
DEA	Drug Enforcement Agency
DFSM	Division of Fee for Service Management
DHCM	Division of Health Care Management
DSH	Disproportionate Share Hospital Report
EFT	Electronic Funds Transfer
EIN	Employer Identification Number
EH	Eligible Hospital
EHR	Electronic Health Record
EHR IP	Electronic Health Record Incentive Program
EP	Eligible Professional
ePIP	Electronic Provider Incentive Payment System
FFY	Federal Fiscal Year (used by Eligible Hospitals in the EHR Incentive Program)
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
FY	Fiscal Year (used by Hospitals)
GOER	Governor's Office of Economic Recovery
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HINAz	Health Information Network of Arizona
HIX	Health Insurance Exchange
HSAG	Health Services Advisory Group
HRSA	Health Resources Services Administration
I&A	CMS Identity & Access Management
IAPD	Implementation Advanced Planning Document

ICD-9/10	International Classification of Diseases
IHS	Indian Health Services
ITU	IHS**,** Tribal & Urban Indian Health Facilities (also referred to as IHS and 638 tribally Operated Facilities)
LEIE	List of Excluded Individuals/Entities

Acronym	Definition
MCO	Managed Care Organization
MCR	Medicare Cost Report
MED	Medicare Exclusion Database
MU/MU1	Meaningful Use; Meaningful Use for first year
MMIS	Medicaid Management Information Systems
NIHB	National Indian Health Board
NLR	National Level Repository; also known as CMS Registration & Attestation System
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration System
OALS	Office of Administrative legal Services
OAH	Office of Administrative Hearings
OIG	Office of Inspector General
ONC	Office of the National Coordinator for Health Information Technology
ONC-ATCB	Office of the National Coordinator - Authorized Testing & Certification Board
OTP	Opioid Treatment Provider
PA	Physician Assistant
PMMIS	Prepaid Medicaid Management Information System
R&A	CMS Registration and Attestation System
REC	Regional Extension Center
RHBA	Regional Behavioral Health Authority
RHC	Rural Health Clinic
RPMS	Resource and Patient Management System
SHIP	Statewide HIE Integration Plan
SMA	State Medicaid Agency
SMHP	State Medicaid Health Information Technology Plan
SSI	Supplemental Security Income
TIN	Taxpayer Identification Number; (Also see Payee TIN)

Appendix F.2: Description of AHCCCS Executive Offices and Divisions

Executives - Office of the Director	
Director	The Director has overall responsibility for ensuring that the Agency meets the goals established in the Agency strategic plan and insures that the organization has the administrative infrastructure to meet the needs of the Agency. The Director provides strategic direction and manages high level, critical issues for the Agency at the local, state and federal levels. Through the Executive Staff, the Director manages all aspects of the Agency's business processes and is responsible for implementing and developing administrative policies and procedures to support the delivery of health care services for over one million AHCCCS members.
Deputy Director	Under the general direction of the Agency Director, the Deputy Director assumes responsibilities of the Director in his/her absence or discretion and represents the Agency among a wide range of Agency stakeholders. The Deputy Director oversees the majority of the Agency operations and is responsible for providing counsel and recommendations to the Director on Agency issues and programs.
Chief Medical Officer	The Chief Medical Officer (CMO) oversees the quality and delivery of healthcare services provided by AHCCCS health plans and contractors. The Chief Medical Officer approves AHCCCS medical policies and assures the appropriate evaluation of the health plan's and contractor's compliance. The CMO can serve as an expert witness on behalf of AHCCCS and the state on legal and regulatory matters involving the provision of medical care services and assists in evaluating and resolving member and provider grievances if they were not resolved at lower levels.
Divisions Reporting to the Director of AHCCCS	
Office of Inspector General Deputy Director Chief Medical Officer Administrative Legal Services Fee for Service Management Healthcare Advocacy and Advancement Human Resources and Development HIT Coordinator Project Management/Payment Modernization Office of Intergovernmental Relations Continuous Improvement	
Divisions Reporting to the Deputy Director of AHCCCS	
Business and Finance Business Intelligence and Analytics Information Services Health Care Management and Rate Development	
Divisions Reporting to the Chief Medical Officer of AHCCCS	
Clinical Services Clinical Project Manager Clinical Initiatives Project Manager	

Appendix F.3: Flexibility Amendment Planning and Approval

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AHCCCS
Arizona Health Care Cost Containment System

Janice K. Brewer, Governor
Thomas J. Betlach, Director

October 30, 2014

Hye Sun Lee
Acting Regional Administrator
Centers for Medicare and Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, California 94103-6706

RE: Arizona 2014 Flexibility Rule Changes for SMHP

Dear Ms Lee:

ONC released a final rule that allows providers participating in the EHR Incentive Programs to use the 2011 Edition of certified electronic health record technology (CEHRT) for calendar and fiscal year 2014. The rule grants flexibility to providers who are unable to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014 due to delays in 2014 CEHRT availability. Providers may now use EHRs that have been certified under the 2011 Edition, a combination of the 2011 and 2014 Editions, or the 2014 Edition for 2014 participation.

State Medicaid Agencies were required to submit by November 1st 2014 a description of how it will accommodate providers who choose this option when attesting for the EHRS Incentive Program. Attached please find the state of Arizona's 2014 State Medicaid HIT Plan amendment as required. Please contact Lorie Mayer at Lorie.Mayer@azahcccs.gov or (602) 417-4420 should you have any questions or need any additional information.

Sincerely,

Thomas J. Betlach
Director

cc: Stephen Chang, Region 9 HITECH Rep
Robert McCarthy, HITECH Contact

801 East Jefferson, Phoenix, AZ 85034 • PO Box 25520, Phoenix, AZ 85002 • 602-417-4000 • www.azahcccs.gov

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AHCCCS
Arizona Health Care Cost Containment System

Janice K. Brewer, Governor
Thomas J. Betlach, Director

SMHP Addendum for Implementation of the 2014 Flexibility Rule:
Arizona EHR Incentive Program

On October 1, 2014 a new Flexibility Rule went into effect for Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The Rule outlines changes to Program Year 2014 attestation submissions, centering on increased flexibility around 2014-certified EHR technology and how providers can demonstrate Meaningful Use (MU). The Arizona EHR Incentive Program is committed to offering eligible providers the flexibility provided to them in the Final Rule.

Arizona is not anticipating substantial changes to the attestation process; however, the changes that are needed are still considered a major system build and will therefore take time to implement. Arizona is anticipating that the Rule will be implemented in March 2015 so that providers who meet the Flexibility requirements can complete attestations at that time. Stage 1 and Stage 2 will be open for attestation prior to February; however, only the original 2014 requirements will be accessible.

System Changes

AHCCCS is planning the following system changes in order to accommodate the Flexibility Rule:

- Creation of a Certified EHR Technology (CEHRT) selection screen for providers to supply relevant CEHRT number(s)
- Creation of a Flexibility "pathway" screen that builds upon the CEHRT screen entry – providers will be presented with all possible attestation options based on the CEHRT number(s) submitted
- Creation of a Flexibility statement that clearly outlines the reasons that an EP may choose to meet Meaningful Use using the Flexibility option
- Reintroduction of Program Year 2013 Stage 1 Meaningful Use attestation that is linked from the pathway screen described above
- Logic changes around CEHRT requirements and Participation exceptions (e.g. more than two years of Stage 1 = ok)
- Linking the 2014 system to the pathway screen

AHCCCS does not use a vendor for EHR attestations. The AHCCCS Information Services Division (ISD) built and maintains the Electronic Provider Incentive Payment (ePIP) system where providers can electronically submit their EHR attestation. ePIP is one of many high-level priorities for ISD; while maintenance and system changes are scheduled as quickly as possible, the ISD resources must remain balanced for all AHCCCS systems and programs. AHCCCS considered processing manual (paper) attestations prior to system implementation; however, there were two concerns that ultimately led to the decision to wait for the automated system: 1) paper-based processing is counter-intuitive the underlying purpose of the EHR Incentive Program and 2) systematic checks to ensure compliance as well as long-term tracking/documentation would be limited, increasing Agency risk for improper payments and incomplete audit trails.

Planning meetings regarding needed system changes have been under way since the Notice of Proposed Rule was released. All requirements have been outlined and system changes are underway. The programming is expected to take two months, followed by both internal and external testing before the new attestation system is moved to production.

Attestation Process

AHCCCS is not anticipating much change to the attestation process. Once system changes are in place, providers will be able to access ePIP as they normally would in order to complete an attestation. AHCCCS is concerned about provider's knowledge of the Flexibility changes and what each option entails. Extensive education will be made available on the AHCCCS website and via the Arizona EHR Program Hotline and Email Inbox. Arizona is also

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Flexibility Application Page 3 of 5

considering other methods of outreach to provide education on the Flexibility requirements and attestation process; however, final decisions have not yet been made.

Extended Tail Period

Due to the programming complexities of the Flexibility Rule and the associated timeline for ISD staff to complete the work, AHCCCS would like permission to extend the Program Year 2014 Attestation Tail Period through June 2015 for Eligible Professionals (EPs). If approved, it would allow providers three months to complete their attestations and also provide enough time to offer technical assistance if providers are uncertain about the Flexibility Rule and related attestation process.

AHCCCS is also seeking approval to extend the Eligible Hospital (EH) attestation tail period. While the vast majority of attestation data comes directly from CMS via attestations that EHs complete with them, there is still a need to EHs to upload proof of Medicaid eligibility. At this time, ePIP cannot accept EH data due to system enhancements that are under way. With such in mind, the requested tail period for EHs is through March 2015.

Pre-Payment Review Process

AHCCCS is not anticipating major change to the pre-payment review process. All attestations will go through a thorough review to ensure that providers meet the qualifications and requirements outlined in the Final Rule. Review staff will be trained on all attestation scenarios outlined in the Final Rule to ensure efficient review of each attestation, regardless of which option the provider selected. Attestations will be compared against federal requirements related to the chosen attestation type along with Agency Business Intelligence data to assure attestation reasonableness.

Additionally, for those EPs who opt to meet Meaningful Use via the Flexibility pathway, AHCCCS will develop a policy that describes validation of provider eligibility/options related to CMS Flexibility guidance.

Post-Payment Audit Process

AHCCCS is not anticipating major changes to the post-payment audit process. AHCCCS aligns its EHR audit protocols with issued CMS guidance. Risk assessment will be conducted during the pre-payment review process; EHR auditors will review those assessments along with other elements that AHCCCS considers when selecting audits. Providers that do not fall into a high-level risk category will be randomly selected for a desk-level audit. If a provider audit cannot be completed at the desk-level or the concerns are great enough to warrant such, onsite audits will be conducted.

Protocols specific to the attestation type will be applied for the audit process as is standard practice currently. AHCCCS will review its current Audit Strategy and revise as needed to incorporate risk factors and audit elements related to Flexibility. AHCCCS will review all guidance issued from CMS, including any updates to the Audit Strategy Toolkit and Community of Practice discussions.

Appeal Process

There will be no change to the Appeal Process. If AHCCCS issues a rejection or denial for any reason (including not meeting Flexibility requirements), the provider will be given the standard 30-day timeframe to request a hearing.

Summary

AHCCCS will fully implement Flexibility Rule requirements over the next four months; it is anticipated that the Final Rule will be fully implemented in March 2015. The majority of changes will be to the attestation system (ePIP), with limited impact to ongoing administrative processes. All staff will be fully trained on each attestation type as well as what is considered acceptable supporting documentation for each. Additionally, the system will allow for a selection of attestation options that either currently exist or have existed in previous years for the Program; review protocols will not deviate from pre-established processes. If an unforeseen barrier does arise,

2

Flexibility Application Page 4 of 5

AHCCCS will seek technical assistance from the appropriate CMS contact if the issue cannot be resolved by the Agency.

It was noted in a recent CMS All States call that additional guidance will be made available to states as they implement the Flexibility Rule. AHCCCS will review all issued guidance and incorporate any changes that do not aligned with the planned implementation strategy outlined above. AHCCCS looks forward to ongoing coordination related to Flexibility and appreciates any additional information that CMS may provide.

October 31, 2014

Flexibility Application Page 5 of 5

Arizona Checklist for 2014 CEHRT Flexibility Rule:

Flexibility Rule Changes Effective October 1, 2014		State Checklist - Implementation Status				
Subject	**Change**	**Target Date**	**Not Started**	**In Process**	**Complete**	**Notes**
SMHP/IAPD	Submit SMHP Addendum to CMS	Nov.1, 2014				HITECH mailbox; RO Director; RO Rep; Letter from Director to accompany addendum.
	Submit IAPD-U to CMS, if additional FFP needed	Nov. 2014				Additional funding for system build and changes in ePIP.
General Policy Changes	Review/update policies as it may relate to the Flexibility Rule	Jan. 2015		X		
	Determine parameters defining acceptable reasons that providers were unable to fully implement 2014 Edition CEHRT	Feb. 2015		X		Discuss – Review CMS Hardship Exemption criteria.
	Determine CEHRT verification process providers will use				X	Same as other.
	Review/update pre-payment verification documentation requirements	Jan. 2015		X		
Systems/ Infrastructure	Design system changes and develop system requirements	Nov. 2014		X		
	Develop system changes	Feb. 2015		X		
	Test system changes	Mar. 2015	X			
	Determine if attestation tail period needs extended	June 2015		X		
Outreach	Implement outreach strategy for stakeholders	March 2015		X		
	Provide training for SMA staff/vendors that field phone/email questions from providers	Ongoing		X		
Auditing	Update post-payment audit procedures to incorporate Flexibility Rule	April 2015	X			
	Review/update audit risk profile(s) to reflect Flexibility Rule	March 2015	X			

CMS Flexibility Approval

Subject: CMS Approval Arizona SMHP Addendum 1-20-15
Importance: High

Thank you for your letter, dated October 30, 2014, requesting that the Centers for Medicare & Medicaid Services (CMS) review and approve an addendum to the CNMI State Medicaid Health Information Technology Plan (SMHP). This SMHP addendum was submitted in response to our recent final rule at 79 FR 52910 (September 4, 2014), which grants flexibility to eligible providers who are unable to fully implement 2014 Edition certified electronic health record technology (CEHRT) for an EHR reporting period in 2014 due to delays in 2014 CEHRT availability.

CMS approves the addendum to Arizona's SMHP effective as of the date of this email transmission. Our approval of Arizona's addendum is subject to the provisions in regulations at 42 CFR Part 495 Subpart D.

Additionally, in the next SMHP submission, CMS requests Arizona:

1. Provide updates on when changes to policies will be completed as they relate to the Flexibility Rule.
2. Provide a description of any outreach efforts as they relate to the flexibility rule.
3. Provide updates on when system design changes and system requirements will be completed.
4. Provide updates on when additional information will be added as they relate to the risk profiles established in the Audit Strategy, in regards to the provider flexibility option.

Please note: the information included in this addendum must be incorporated into the next official SMHP submission and noted in a change control document specifying where in the SMHP the Addendum has been added.

If you have any questions or concerns regarding this information, please let me know.

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Figure 24: Flexibility Rule Web Page

Flexibility Rule

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) released a final rule in August 2014 that grants flexibility for providers who are unable to fully implement 2014 Edition certified electronic health record (EHR) technology (CEHRT) for the 2014 reporting year. Providers may use EHRs that have been certified under the 2011 Edition, 2014 Edition, or a combination of the 2011 and 2014 Editions to submit meaningful data for an EHR reporting period in 2014.

Only providers who have been unable to fully implement 2014 CEHRT can take advantage of the rule's flexibility options.

Providers will be required to report using 2014 Edition CEHRT beginning in 2015.

CEHRT Flexibility Resources

To help you understand the final rule's changes to 2014 participation, CMS has developed the following resources. Click the link to learn more.

Educational Resources: CMS has a number of resources to help you participate in the programs.

Final Rule: Regulation that grants flexibility to providers who are unable to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014 due to delays in 2014 Edition CEHRT availability.

CEHRT Flexibility Decision Tool: Providers answer a few questions about their 2014 stage of meaningful use and Edition of EHR certification, and the tool displays the corresponding 2014 options.

2014 CEHRT Flexibility Chart: Chart provides a visual overview of CEHRT participation options for 2014.

2014 CEHRT Rule Quick Guide: Explains the participation options for 2014 based on the Edition of EHR certification providers used during 2014.

Figure 23: Flexibility Rule Web Page (Continued)

Medicaid EHR Incentive Program Flexibility Resources: Arizona has developed the following companion resources. Click the links to learn more.

The CMS 2014 Flexibility Rule is an option available to providers attesting to meaningful use. Vendor documentation is required to support use of the Flexibility Rule.

The CMS 2014 Flexibility Rule does not apply to providers attesting to Adopt, Implement or Upgrade (AIU). Providers attesting to AIU are required to meet the 2014 Edition certification criteria.

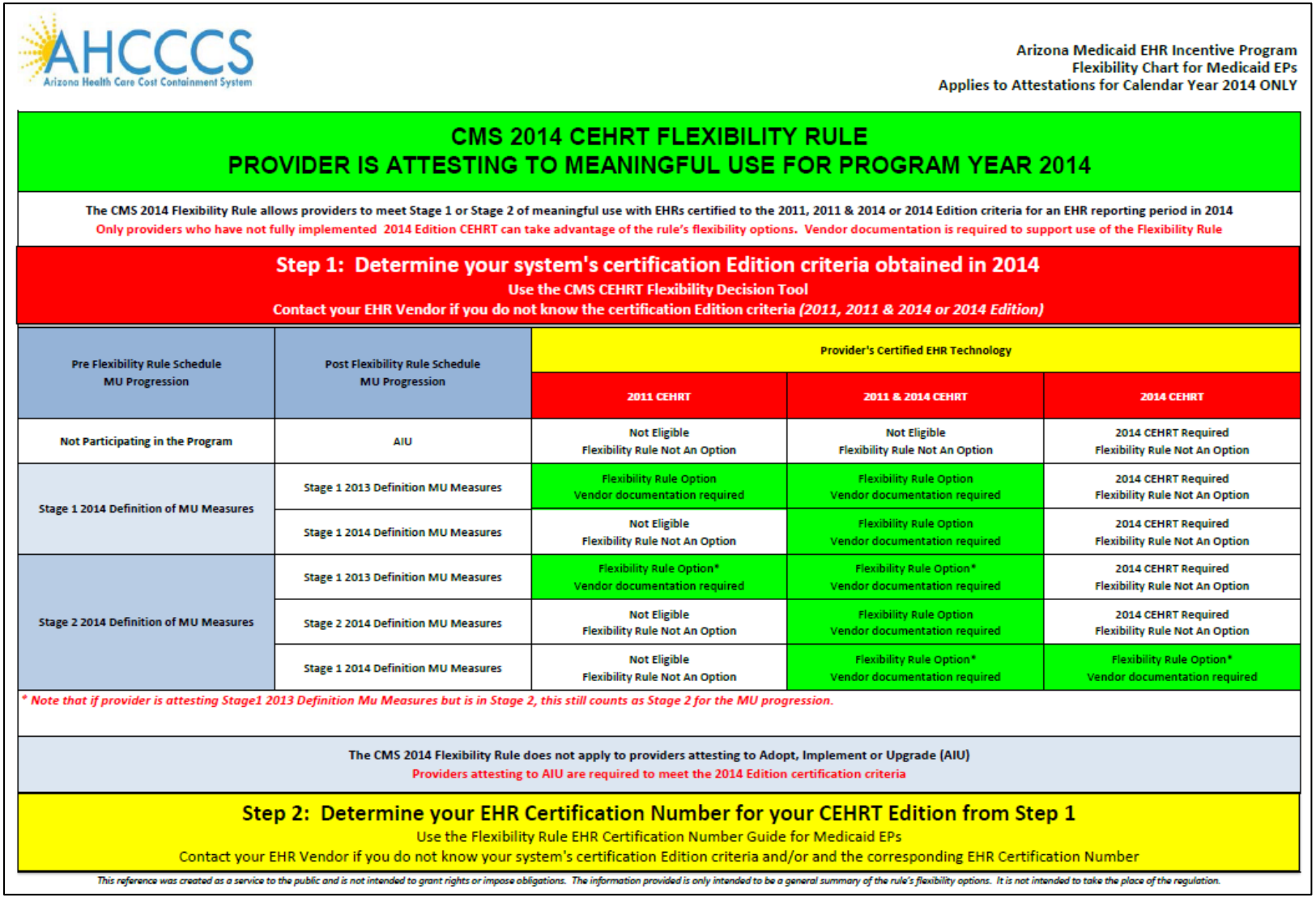
Flexibility Chart for Medicaid EPs: High-level overview of the CEHRT options available to providers due to the 2014 CHERT Flexibility Rule. Use in conjunction with the CMS CEHRT Flexibility Decision Tool.

Flexibility EHR Certification Number Guide for Medicaid EPs: High-level overview of the system's EHR Certification Number for the corresponding CEHRT option selected by the provider due to the 2014 CHERT Flexibility Rule. Use in conjunction with the CMS CEHRT Flexibility Decision Tool.

Click here to link to the CMS CEHRT Flexibility Decision Tool.

Disclaimer: The above tools were created as a service to the public and are not intended to grant rights or impose obligations. The information provided is only intended to be a general summary of the rule's flexibility options. It is not intended to take the place of the regulation.

Figure 24: Flexibility Rule



AHCCCS
Arizona Health Care Cost Containment System

Arizona Medicaid EHR Incentive Program
Flexibility Chart for Medicaid EPs
Applies to Attestations for Calendar Year 2014 ONLY

CMS 2014 CEHRT FLEXIBILITY RULE
PROVIDER IS ATTESTING TO MEANINGFUL USE FOR PROGRAM YEAR 2014

The CMS 2014 Flexibility Rule allows providers to meet Stage 1 or Stage 2 of meaningful use with EHRs certified to the 2011, 2011 & 2014 or 2014 Edition criteria for an EHR reporting period in 2014

Only providers who have not fully implemented 2014 Edition CEHRT can take advantage of the rule's flexibility options. Vendor documentation is required to support use of the Flexibility Rule

Step 1: Determine your system's certification Edition criteria obtained in 2014

Use the CMS CEHRT Flexibility Decision Tool

Contact your EHR Vendor if you do not know the certification Edition criteria *(2011, 2011 & 2014 or 2014 Edition)*

Pre Flexibility Rule Schedule MU Progression	Post Flexibility Rule Schedule MU Progression	Provider's Certified EHR Technology		
		2011 CEHRT	2011 & 2014 CEHRT	2014 CEHRT
Not Participating in the Program	AIU	Not Eligible Flexibility Rule Not An Option	Not Eligible Flexibility Rule Not An Option	2014 CEHRT Required Flexibility Rule Not An Option
Stage 1 2014 Definition of MU Measures	Stage 1 2013 Definition MU Measures	Flexibility Rule Option Vendor documentation required	Flexibility Rule Option Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
	Stage 1 2014 Definition MU Measures	Not Eligible Flexibility Rule Not An Option	Flexibility Rule Option Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
Stage 2 2014 Definition of MU Measures	Stage 1 2013 Definition MU Measures	Flexibility Rule Option* Vendor documentation required	Flexibility Rule Option* Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
	Stage 2 2014 Definition MU Measures	Not Eligible Flexibility Rule Not An Option	Flexibility Rule Option Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
	Stage 1 2014 Definition MU Measures	Not Eligible Flexibility Rule Not An Option	Flexibility Rule Option* Vendor documentation required	Flexibility Rule Option* Vendor documentation required

** Note that if provider is attesting Stage1 2013 Definition Mu Measures but is in Stage 2, this still counts as Stage 2 for the MU progression.*

The CMS 2014 Flexibility Rule does not apply to providers attesting to Adopt, Implement or Upgrade (AIU)

Providers attesting to AIU are required to meet the 2014 Edition certification criteria

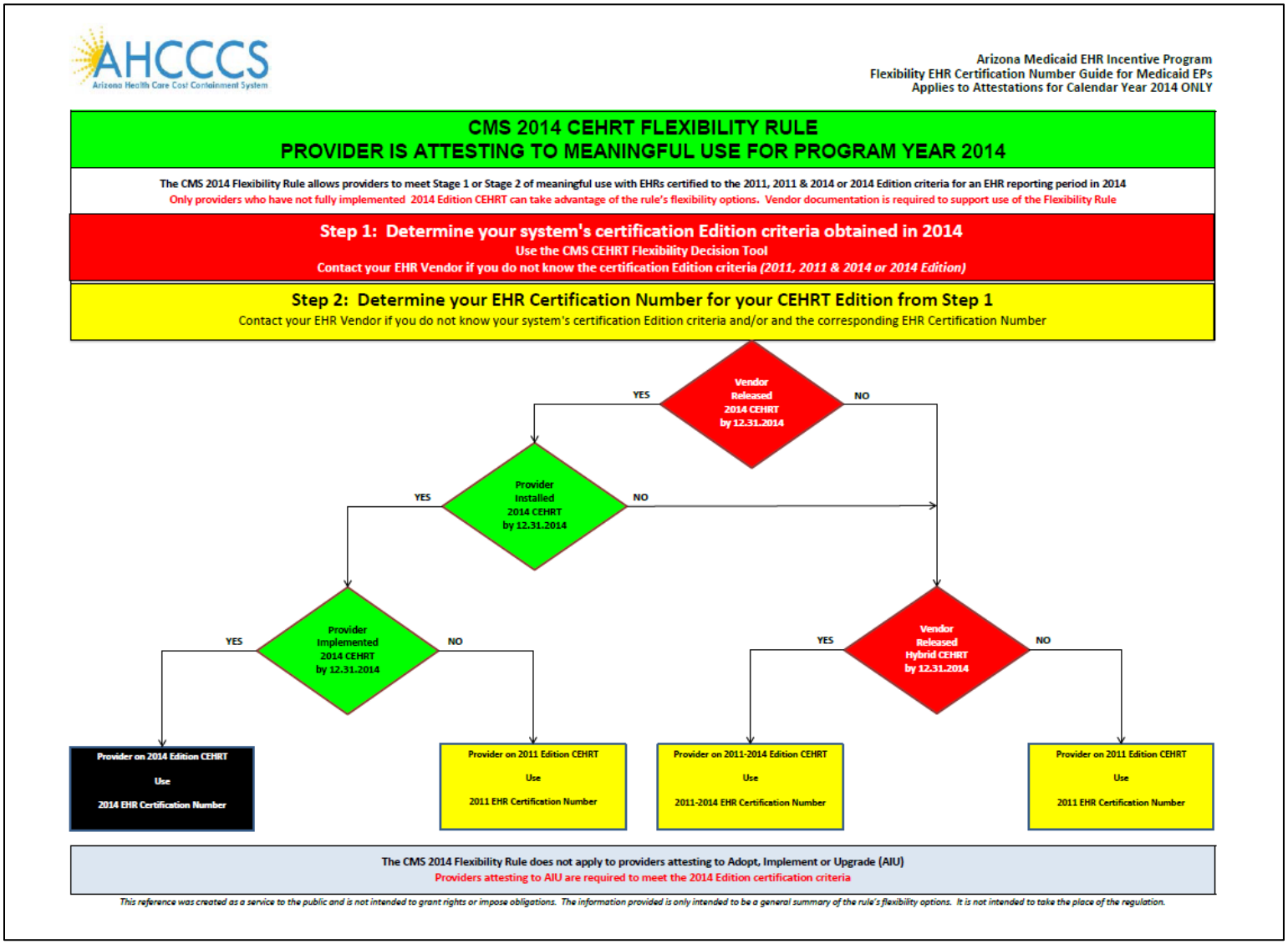
Step 2: Determine your EHR Certification Number for your CEHRT Edition from Step 1

Use the Flexibility Rule EHR Certification Number Guide for Medicaid EPs

Contact your EHR Vendor if you do not know your system's certification Edition criteria and/or and the corresponding EHR Certification Number

This reference was created as a service to the public and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary of the rule's flexibility options. It is not intended to take the place of the regulation.

Figure 25: EHR Certification Number Guide



Appendix F.4: Full Survey Questions – Environmental Scan – EP Online Survey

Environmental Scan Eligible Professional Online Survey Questions

AHCCCS conducted an online survey to those providers who attested between 2013 and 2015 to get feedback from them on how the SMA could improve the Registration and Attestation process for those Medicaid Eligible Professionals participating in the EHR Incentive Program. A summary of the results and the parameters of the survey are discussed in section A.1.

A full copy of the online survey questions is provided below.

AHCCCS
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AHCCCS EHR Incentive Program Survey

Background Information

AHCCCS is responsible for the implementation and oversight of the Medicaid Electronic Health Record Incentive Program. The program is sometimes referred to as Meaningful Use.

AHCCCS wants feedback about your experience with the EHR Incentive Program portal and the agency's customer service. Please complete this short online survey to help us improve your future experience with the EHR Incentive Program.

This survey is anonymous.

1

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS EHR Incentive Program Survey

General Information

* 1. Provider Type

Provider Type

Choose Your Provider Type

* 2. Are you a pediatrician?

- Yes
- No

* 3. County in which services are provided

County

If you provide services in more than one county, please select the county where you provide the majority of your services.

* 4. Do you plan to continue to participate in the AHCCCS EHR Incentive Program by attesting to the next stage of Meaningful Use?

- Yes
- No

5. Why or Why not? (Please explain your answer for question #4 below).

* 6. How would you rate your overall experience with the AHCCCS EHR Incentive Program?

Poor Fair Good Very good Excellent

2

7. How could your experience be improved?

* 8. How many times have you attested with the AHCCCS ePIP system (Electronic Provider Incentive Payment System)?

- One time
- Two times
- Three times
- Four Times

3

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS EHR Incentive Program Survey

AHCCCS ePIP(Electronic Provider Incentive Payment System) Overall Experience

AHCCCS has created a provider portal called ePIP (Electronic Provider Incentive Payment System) to administer the EHR Incentive Program. Providers use ePIP to register, submit documents and track Meaningful Use payments.

9. How would you rate your overall experience with the AHCCCS ePIP portal?

◯ Poor ◯ Fair ◯ Good ◯ Very good ◯ Excellent

10. How could your experience be improved?

4

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS EHR Incentive Program Survey

AHCCCS ePIP (Electronic Provider Incentive Payment System) Registration

11. Please indicate how much you agree or disagree with each of the following statements about the AHCCCS ePIP (Electronic Provider Incentive Payment System) registration process.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I found the experience of registering for the Medicaid EHR Incentive Program to be easy.	○	○	○	○	○
Overall, it took me less time than I expected to complete the AHCCCS ePIP registration.	○	○	○	○	○
I did not require assistance in order to complete my AHCCCS ePIP registration.	○	○	○	○	○
After I completed the registration process, I understood what the next step of the EHR Incentive Program was.	○	○	○	○	○

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AHCCCS
Arizona Health Care Cost Containment System

AHCCCS EHR Incentive Program Survey

Provider Experience with ePIP functionality

12. Please indicate how much you agree or disagree with each of the following statements on the functionality of the AHCCCS ePIP (Electronic Provider Incentive Payment System) portal.

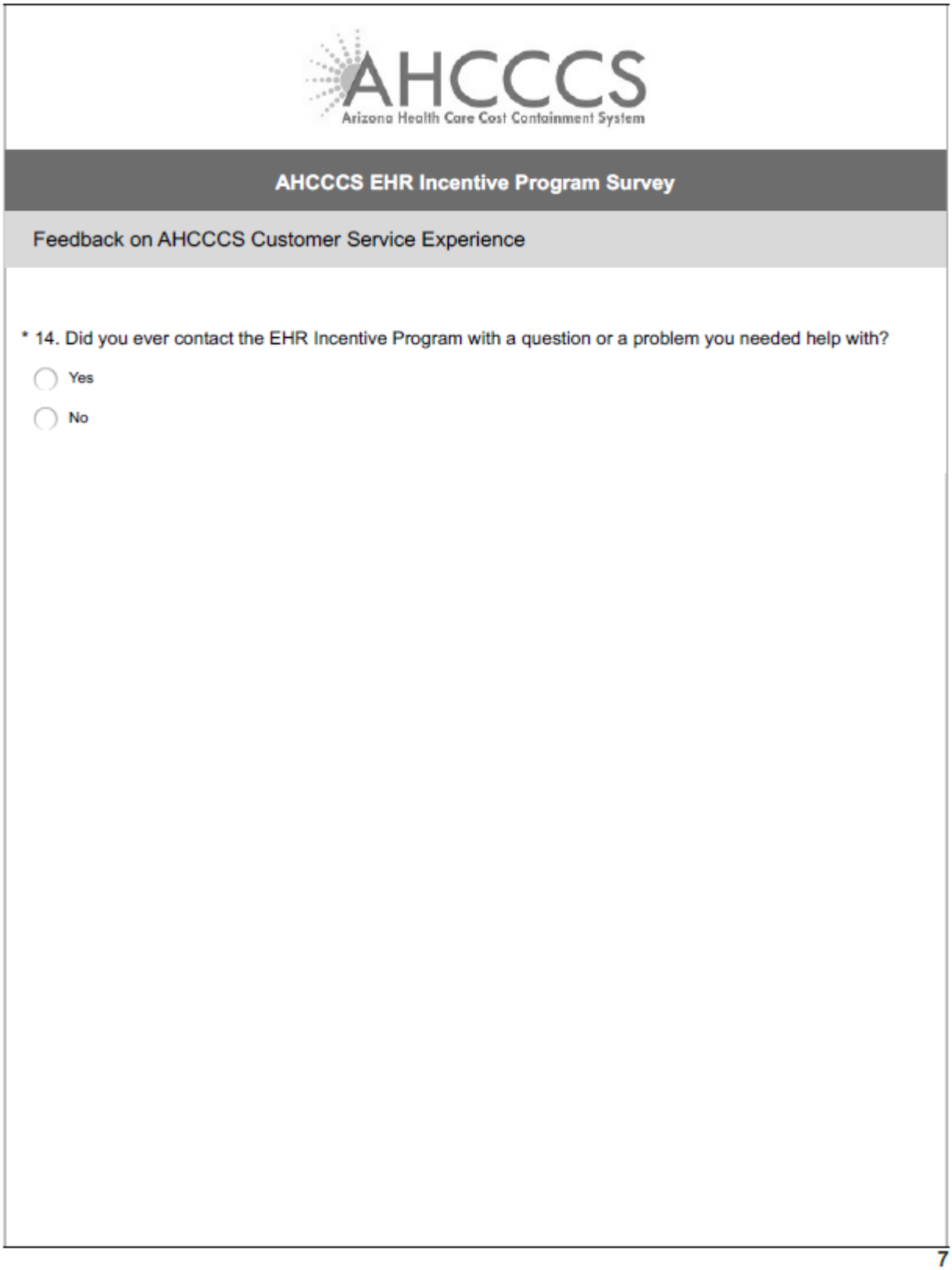
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
It was easy for me to login to my ePIP portal.	○	○	○	○	○
It was easy for me to navigate the ePIP pages.	○	○	○	○	○
The directions in the ePIP portal were clear and easy to follow.	○	○	○	○	○
I understood which documents I needed to upload into the ePIP portal.	○	○	○	○	○

13. The data elements that were the most difficult for me to provide to AHCCCS were (check all that apply):

- ☐ EHR Certification Number
- ☐ Tax Identification Number
- ☐ Proof of EHR Vendor Contracts
- ☐ Hospital Based Ecounters
- ☐ Medicaid Patient Encounters
- ☐ Patient Volume Report
- ☐ Total Patient Encounters

Other (please specify)

6


AHCCCS
Arizona Health Care Cost Containment System
AHCCCS EHR Incentive Program Survey
Feedback on AHCCCS Customer Service Experience
* 14. Did you ever contact the EHR Incentive Program with a question or a problem you needed help with?
Yes
No
7

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS EHR Incentive Program Survey

Feedback on AHCCCS Customer Service Experience

15. Which method did you use to contact the EHR Incentive Program with your question or concern? (check all that apply):

- ☐ Email
- ☐ Phone

16. Based on your customer service experience with the EHR Incentive Program, please indicate how much you agree or disagree with each of the following statements.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I was satisfied with the response I received from AHCCCS staff.	○	○	○	○	○
AHCCCS staff handled my questions or concerns in a timely manner.	○	○	○	○	○
I found the staff to be knowledgeable.	○	○	○	○	○
I found the staff to be friendly and courteous throughout.	○	○	○	○	○

8

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS EHR Incentive Program Survey

Feedback on AHCCCS Customer Service Experience

17. What is your preferred method of getting your question/concern answered in the future? (check all that apply):

- [ ] Email
- [ ] Phone

18. What would be the best times for the EHR Incentive Program Team to contact you if you requested help in completing your attestation? (check all that apply)

- [ ] Early Morning 05:00 AM - 09:00 AM
- [ ] Late Morning 09:00 AM - 12:00 PM
- [ ] Early Afternoon 12:00 PM - 03:00 PM
- [ ] Late Afternoon 03:00 PM - 05:00 PM
- [ ] Early Evening 05:00 PM - 08:00 PM

9

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS EHR Incentive Program Survey

Feedback on EHR Incentive Program Education Resources

AHCCCS has a variety of education materials on its EHR Incentive Program website (www.azahcccs.gov). The materials include an EHR process diagram, forms for estimating and documenting patient volume, as well as registration and attestation reference guides.

19. How useful were the education resources provided on the AHCCCS website for the ePIP registration and attestation process?

◯ Never Accessed ◯ Not at all useful ◯ Not very useful ◯ Somewhat useful ◯ Very useful

20. What kind of customer service support and/or educational materials would be beneficial to you as you continue in the EHR Incentive Program?

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AHCCCS
Arizona Health Care Cost Containment System

AHCCCS EHR Incentive Program Survey

Arizona Regional Extension Center (REC) Experience

The Arizona Regional Extension Center (REC), a program of Arizona Health-e Connection (AzHeC), provides an unbiased approach in utilizing health IT to improve and transform health care delivery and practice. One of 62 federally funded and designated RECs nationwide, the REC is a single resource to provide essential services from adoption through all requirements for achieving Meaningful Use and receiving EHR incentive payments. The REC today serves all Arizona providers regardless of size or specialty.

21. Have you ever been a member or received assistance from the REC?

- ◯ Yes
- ◯ No

22. At the time you received your first Medicaid EHR payment, were you a member of the REC or receiving assistance from the REC?

- ◯ Yes
- ◯ No

23. How would you rate your experience with the Arizona REC?

◯ Poor ◯ Fair ◯ Good ◯ Very good ◯ Excellent

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AHCCCS
Arizona Health Care Cost Containment System

AHCCCS EHR Incentive Program Survey

Future Attestation

24. What type of customer service offering or educational tool would help you to complete the next stage of meaningful use?

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Appendix F.5: HIE Financial Statements (Submitted Under Separate Cover)

Appendix F.6 Statewide HIE Integration Plan (SHIP)

Arizona Health-e Connection
The Network

Statewide HIE Integration Plan (SHIP)

High Priority Providers for Connectivity

The Network, operated by Arizona Health-e Connection (AzHeC), serves as a community **data trustee** and a **network of networks** that allows participants to save time and resources and create a more comprehensive patient record providing the right information at the right time and place.

The Statewide HIE Integration Plan (SHIP) calls for integration of behavioral health information into the statewide health information exchange. The three Arizona Regional Behavioral Health Authorities (RHBAs) have funded AzHeC to connect the top 100 behavioral health providers listed below to The Network by May 2018.

Behavioral Health – Community Providers (72)

A New Leaf
Arizona's Children Association (AzCA)
Arizona Counseling & Treatment Services
Assurance Health & Wellness (dba Sinfonia)
Aurora Behavioral Health Systems, LLC[1]
BAART Behavioral Health Services
Banner University Whole Health Clinic, Epicenter & CRC
Bayless Healthcare Group
Casa De Los Ninos
ChangePoint Integrated Health[5]
CHEEERS, Inc
Chicanos Por La Causa (CPLC)
Child Crisis Center
Child & Family Support Services
CODAC Health Recovery Wellness, Inc.
Community Bridges, Inc.
Community Health Associates
Community Provider of Enrichment Services, Inc (CPES)
ConnectionsAZ
COPE Community Services
Corazon Integrated Healthcare Services
Crisis Preparation & Recovery (CPR)
Crisis Response Network (CRN)
Crossroads Mission
Devereux Arizona
Easter Seals Blake Foundation
Ebony House, Inc
Encompass Health Services
Family Involvement Center
Focus Employment Services
Grace Behavioral Health
Helping Associates, Inc.
HOPE Group, LLC / Highland Behavioral Health
Hope Inc
Hope Lives
Intensive Treatment Systems
Intermountain Centers for Human Development
Jewish Family and Children's Service (Phoenix)
La Frontera - EMPACT
La Frontera Center, Inc.
LifeShare Management Group
Lifewell Behavioral Health and Wellness
Little Colorado Behavioral Health Center
Marc Community Resouce Inc (Marc Center)
Mentally Ill Kids in Distress (Mikid)
Mohave Mental Health Clinics, Inc[2]
Native American Connections
NAZCARE
New Hope of Arizona
New Horizons Counseling Services, Inc
NurseWise
Old Pueblo Community Services
Partners in Recovery
Pasadera Behavioral Health Network
Pathways of Arizona (formerly Providence)
Pinal Hispanic Council (PHC)
PSA Behavioral Health Agency
Recovery Empowerment Network (REN)
Recovery Innovations
S.E.E.K. Arizona
Southeastern Arizona Behavioral Health Services
Southwest Behavioral & Health Services
Southwest Network
Southwestern Children's Health Services (dba Parc Place) (Oasis Behavioral Health)[3]
Spectrum Healthcare Group, Inc.
Stand Together and Recovery Centers (S.T.A.R.)
The Guidance Center[4]
The Living Center Recovery dba Transitional Living Center Recovery (TLCR)
Touchstone Behavioral Health
Wedco Employment Services
Wellness Connections
West Yavapai Guidance Clinic, Inc.

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Appendix F.6: Statewide HIE Integration Plan (SHIP) (cont'd)

Behavioral Health Hospitals (15)

Arizona State Hospital
Aurora Behavioral Health System[1]
Banner Behavioral Health Hospital
Banner – University Medicine Behavioral Health Clinic
Community Counseling Centers at Pineview Hospital[5]
Maricopa Integrated Health System –Desert Vista & Annex
Mohave Mental Health[2]
Oasis Behavioral Health Hospital[3]
Palo Verde Behavioral Health
Quail Run Behavioral Health
Sonora Behavioral Health Hospital
St Luke's Behavioral Health LP (BH Hospital/Gero/Psych Unit) – Phoenix (IASIS)
The Guidance Center[4]
Valley Hospital
Windhaven Psychiatric Hospital[5]

FQHCs & Community Health Centers (11)

Canyonlands Community Health Center
Circle the City
Desert Senita Community Health Center
El Rio Community Health Center
Horizon Health and Wellness
Marana Health Center
Maricopa Integrated Health System - Clinics
Native American Community Health Center Inc (dba Native Health)
North Country HealthCare
Terros Health
Valle del Sol

Correctional Health Services (5)

Coconino County
Maricopa County
Pima County
Yavapai County
Yuma County

Note: Superscript numbering indicate associated facilities

Appendix F.7: Current Count and Type of HIE Participants

Arizona Health-e Connection
The Network

Who is The Network?

224 participants and growing

The Network, operated by Arizona Health-e Connection (AzHeC), serves as a community data trustee and a network of networks that allows participants to save time and resources and create a more comprehensive patient record providing the right information at the right time and place.

"" Denotes sending data to The Network*

Behavioral Health Providers (69)

A New Leaf
Arizona's Children Association
Arizona Counseling & Treatment Services
Arizona Youth & Family Services, Inc.
Assurance Health & Wellness
Bayless Healthcare Group
Casa De Los Ninos
ChangePoint Integrated Health
Chicanos Por La Causa
Child & Family Support Services
CODAC Health Recovery Wellness, Inc.
Community Bridges, Inc.
Community Health Associates
Community Medical Services
Community Partnership Care Coordination
Community Provider of Enrichment Services, Inc.
ConnectionsAZ
Cope Community Services
Corazon Integrated Healthcare Services
Crisis Preparation & Recovery
Crisis Response Network
Crossroads Mission
Devereux Advanced Behavioral Health Arizona
Easter Seals Blake Foundation
Ebony House, Inc.
Encompass Health Services
Family Involvement Center
Family Service Agency
Helping Associates, Inc.
Hope Incorporated
Human Services Consultants
Intermountain Center for Human Development
Jewish Family & Children's Services
La Frontera Center, Inc.
La Frontera – Empact
LifeShare Management Group
Lifewell Behavioral Wellness
Little Colorado Behavioral Health Centers
Marc Community Resources
Mentally Ill Kids in Distress
Mohave Mental Health Clinics, Inc.
Native American Connections
NAZCARE, Inc.
New Hope of Arizona
NurseWise
Old Pueblo Community Services
Open Hearts Arizona
Partners in Recovery
Pasadera Behavioral Health Network
Pathways of Arizona, Inc.
Pinal Hispanic Council
PSA Behavioral Health Agency
Recovery Innovations
Rio Salado Behavioral Health
San Tan Behavioral Health Services, Inc.
S.E.E.K. Arizona
Sonoran Medical Centers
Southeastern Arizona Behavioral Health Services
Southwest Behavioral & Health Services
Southwest Network
Spectrum Healthcare Group, Inc.
The Crossroads, Inc.
The Guidance Center
The Phoenix Shanti Group
Touchstone Behavioral Health
Wellness Connections
West Yavapai Guidance Clinic, Inc.
Youth Advocate Programs, Inc.
Zarephath

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Appendix F.7: HIE Participant Count and Type (cont'd.)

Arizona Health-e Connection
The Network

Who is The Network?

224 participants and growing

Community Providers (62)

Abrazo Heart Institute
Abrazo Medical Group
Angela Wyatt Dermatology
Arizona Center for Cancer Care
Arizona Community Physicians
Arizona Family Care
Arizona Kidney Disease & Hypertension Centers
Arizona Pain Specialists
ASAP Health Solutions
Barnet Dulaney Perkins Eye Center
Bart J. Carter, MD
Beech Medical Group, Inc.
Catalina Pointe Arthritis & Rheumatology Specialists, P.C.
Children's Clinics (Tucson)*
Christopher Moor, MD
Cigna Medical Group
Colorado River Pediatrics
Deseret Family Medicine
Desert Kidney Associates, PLC
Desert Spine Institute
District Medical Group*
Doc2U
Dorothy L. Wong Medical Offices
East Flagstaff Family Medicine
Enticare
Flagstaff Family Care Clinic
Gila Health Resources
Gila Valley Clinic
Heart and Vascular Center of Arizona
Homewood Family Physicians
MD 24 House Call, Inc.
Med-Cure Internal Medicine
Mountain View Pediatrics
Neuromuscular Research Center
New Pueblo Medicine
Northwest NeuroSpecialists
Options Medical
OptumCare AZ Complex Care Management
OptumCare Medical Group (GPCC)
Page Family Practice
Palo Verde Family Care
Phoenix Medical Group
Pima Heart
Pima Lung & Sleep Center
Pinnacle Care Internal Medicine
Plaza Healthcare
Saguaro Surgical
San Pedro Family Care
Santé Partners, LLC
Sound Physicians
Southern Arizona Infectious Disease Specialists
Southwest Kidney Institute, PLC
Thunderbird Internal Medicine
True Care, MD
Tucson Pulmonology, PC
Universal Care Management
University of Arizona College of Medicine
Valley Anesthesiology & Pain Consultants
Virginia G. Piper St. Vincent DePaul Clinics
Winslow Indian Health Care Center
Yuma Gastroenterology
Yuma Nephrology, PC

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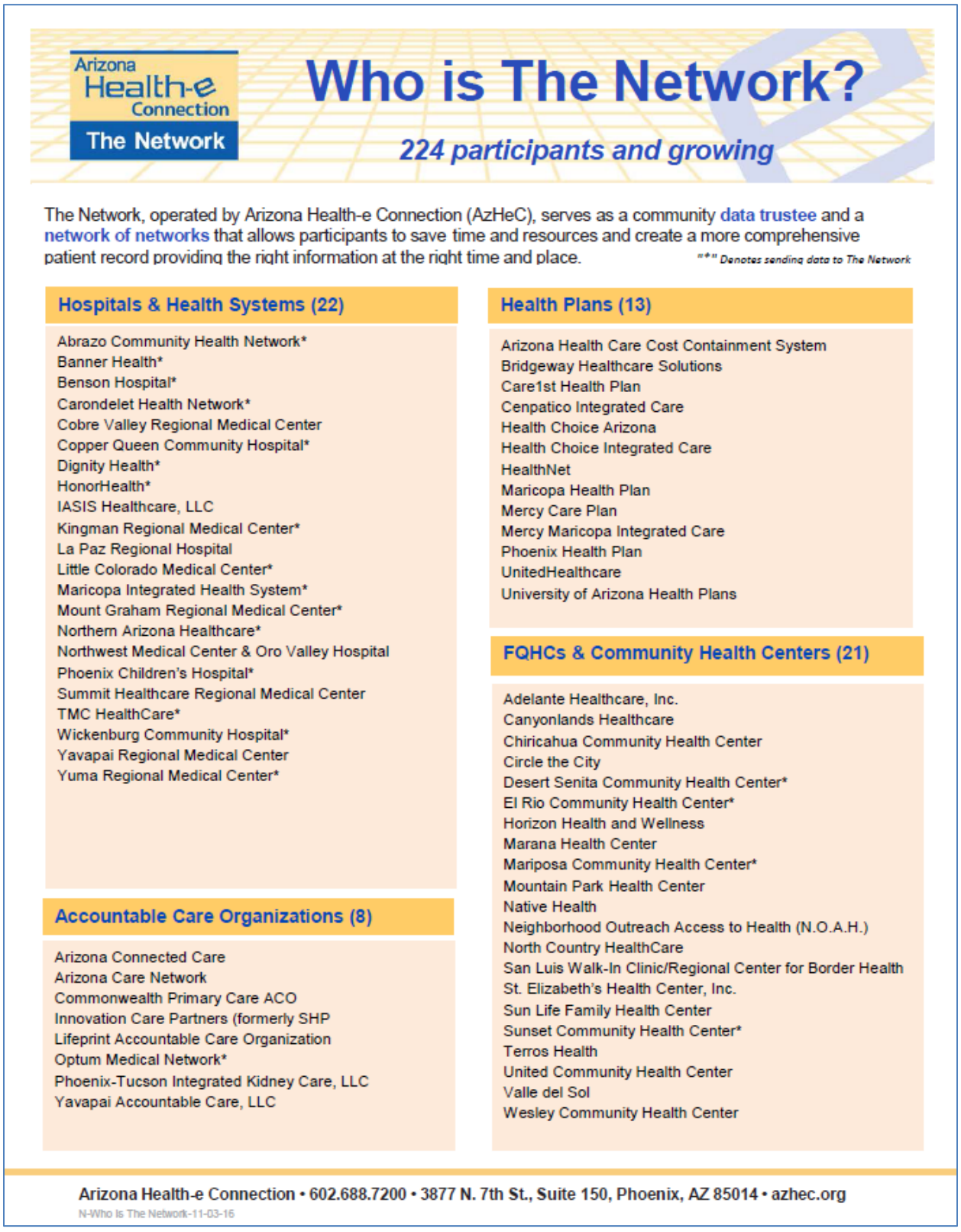
N-Who Is The Network-11-03-16

Appendix F.7: HIE Participant Count and Type (cont'd.)



Arizona Health-e Connection
The Network

Who is The Network?

224 participants and growing

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"" Denotes sending data to The Network*

Hospitals & Health Systems (22)

Abrazo Community Health Network*
Banner Health*
Benson Hospital*
Carondelet Health Network*
Cobre Valley Regional Medical Center
Copper Queen Community Hospital*
Dignity Health*
HonorHealth*
IASIS Healthcare, LLC
Kingman Regional Medical Center*
La Paz Regional Hospital
Little Colorado Medical Center*
Maricopa Integrated Health System*
Mount Graham Regional Medical Center*
Northern Arizona Healthcare*
Northwest Medical Center & Oro Valley Hospital
Phoenix Children's Hospital*
Summit Healthcare Regional Medical Center
TMC HealthCare*
Wickenburg Community Hospital*
Yavapai Regional Medical Center
Yuma Regional Medical Center*

Accountable Care Organizations (8)

Arizona Connected Care
Arizona Care Network
Commonwealth Primary Care ACO
Innovation Care Partners (formerly SHP
Lifeprint Accountable Care Organization
Optum Medical Network*
Phoenix-Tucson Integrated Kidney Care, LLC
Yavapai Accountable Care, LLC

Health Plans (13)

Arizona Health Care Cost Containment System
Bridgeway Healthcare Solutions
Care1st Health Plan
Cenpatico Integrated Care
Health Choice Arizona
Health Choice Integrated Care
HealthNet
Maricopa Health Plan
Mercy Care Plan
Mercy Maricopa Integrated Care
Phoenix Health Plan
UnitedHealthcare
University of Arizona Health Plans

FQHCs & Community Health Centers (21)

Adelante Healthcare, Inc.
Canyonlands Healthcare
Chiricahua Community Health Center
Circle the City
Desert Senita Community Health Center*
El Rio Community Health Center*
Horizon Health and Wellness
Marana Health Center
Mariposa Community Health Center*
Mountain Park Health Center
Native Health
Neighborhood Outreach Access to Health (N.O.A.H.)
North Country HealthCare
San Luis Walk-In Clinic/Regional Center for Border Health
St. Elizabeth's Health Center, Inc.
Sun Life Family Health Center
Sunset Community Health Center*
Terros Health
United Community Health Center
Valle del Sol
Wesley Community Health Center

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N-Who Is The Network-11-03-16

Appendix F.7: HIE Participant Count and Type (cont'd.)

Arizona Health-e Connection
The Network

Who is The Network?

224 participants and growing

Long-Term & Post-Acute Care (11)

BAYADA Home Healthcare, Inc.
CopperSands, Inc.
Foundation for Senior Living
Helping Hearts Residential Facilities
Home Health Insights, Inc.
Kindred Healthcare
Nightingale Homecare
River Gardens, Ltd.
The Gardens Rehab & Care Center
The Legacy Rehab & Care Center
The Lingenfelter Center, Ltd.

Reference Labs & Imaging Centers (2)

LabCorp
Sonora Quest Laboratories*

State & Local Government (14)

Arizona Department of Health Services
Arizona Health Care Cost Containment System
City of Avondale
City of Buckeye
City of Goodyear
City of Peoria
City of Surprise Fire-Medical
Maricopa County
Pima County (Corrections)
Rio Rico Medical & Fire District
Sonoita-Elgin Fire District
Sun City Fire District
Yavapai County
Yuma County Jail District

Health Information Exchange (2)

Quality Health Network (QHN) Western Colorado*
Utah Health Information Network (UHIN)*

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